



Indian Insanes: Lunacy in the 'Native' Asylums of Colonial India, 1858-1912

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Indian Insanes:
Lunacy in the 'Native' Asylums of Colonial India, 1858-1912.

Abstract

The new Government of India did not introduce legislation for 'native' lunacy in colonial India as a measure of social control after the uprisings of 1857-8; discussions about Indian insanes had already occurred in 1856, following asylum and pauper reform in Victorian England. With the 1858 Lunacy Acts, native lunatic asylums occupied an unsteady position between judicial and medical branches of this government. British officers were too constrained by their inexperience of asylums and of India to be effective superintendents and impose a coherent psychiatry within. They relied on their subordinate staff who were recruited from the communities that surrounded each asylum. Alongside staff and patients, the asylums were populated by tea sellers, local visitors, janitors, cooks and holy men, all of whom presented alternate and complementary ideas about the treatment and care of Indian insanes. By 1912, these asylums had been transformed into archetypal colonial institutions, strict with psychiatric doctrine and filled with Western-trained Indian doctors who entertained no alternate belief systems in these colonial spaces. How did these fluid and heterogeneous spaces become the archetypes of colonial power?

Rather than presume commensurability with other colonial spaces such as the native prison and native hospital, or assume that all colonial asylums began as tools of empire and of social control, this dissertation embeds the native lunatic asylum within the social and cultural milieu of mid-century colonial India to argue that the local community was integral to managing these institutions. Tracing the legal, institutional and social

histories of these native asylums, from 1858 to the Lunacy Acts of 1912, this project reveals increasing interventions by the Government of India – the 1861 Indian Penal Code, an 1868 asylum survey, a variety of lunacy amendment acts – to reassert its colonial agenda and capture the transient nature of madness within its imperial gaze. With the rise of the psychiatric expert and the increasingly significant role of medical education in India, the asylum was transformed into a singularly colonial and homogeneous space.

Contents

Abstract	iii
Acknowledgements	vi
Introduction	1
Chapter 1	35
Chapter 2	72
Chapter 3	104
Chapter 4	143
Chapter 5	176
Conclusion	205
Appendix: 1868 survey questions	222
Bibliography	246

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Introduction: A Permeable Institution

In 1872, a patient by the name of “Goorab” escaped from Jubbulpore Asylum in what is now Madhya Pradesh in Central India. He had escaped by jumping over the hedge at the very periphery of the asylum grounds while the asylum attendants were not paying attention. The most interesting part of this story is that his escape was noticed only a couple of months later, when he returned of his own volition; during his absence, neither asylum superintendent nor the Visiting Officials (such as the Inspector-General of Prisons) had realized that this asylum of forty-eight patients had been reduced by one. How could the asylum superintendent not miss one of his patients for so long? Had not there been a head count in two months? Did none of the attendants realize either?

The answer is quite clearly written in the superintendent’s notes. He writes, “I had long believed Goorab and another patient to be one and the same person. Both behaved similarly, sometimes excitable, and other times very lethargic. Their countenance was so alike, I believed Goorab to still be within the grounds.”¹ Imagine the superintendent’s surprise to find “Goorab” arriving at the asylum entrance, seeming “not the worse for wear.”² Apparently the Inspector-General of Prisons had not visited very regularly to reinforce the counting of the asylum’s population, a variety of visitors from the local community (family members, holy men and tea sellers) had occupied much of the attendants’ time, and the patients had been in such good spirits due to a *nautch* (dance) recital by local girls from the nearby villages that no one had thought to check everyone was present. The fact is, this British superintendent could not differentiate between the

¹ Letter of 14 October 1872, V/18/4301, British Library (hereafter BL).

² *Ibid.*

many Indian faces before him. He was thus reliant upon attendants who, being local, could assist him in managing his charges. This reliance upon local knowledge, upon subsidiary actors, was not something that could have occurred in a representative colonial asylum elsewhere.

This anecdote is critically important to revealing the very different nature of lunatic asylums in nineteenth-century India, as compared to their counterparts in Britain and North America. It reveals the number and variety of actors who occupied the asylum space: not just doctors and patients, but local attendants, Official Visitors, family members and even tea sellers. It also shows how permeable the asylum could be, both physically and figuratively to people and ideas. The permeability of the native asylum in India permitted a hybrid practice of care within. Mid-century psychiatry had not yet formed coherent disciplinary boundaries that could be applied in the Indian asylum with any rigor. Its practitioners had limited tools for treatment and care at their disposal. Local ideas could therefore enter the asylum and intermingle with the variable skill set of the British superintendents in charge to produce a heterogeneous or hybrid practice of care. This hybridity was specific to the characteristics of its locale: I argue that every native lunatic asylum was permeable to its surrounding community, but that the level of intermingling, of interaction between different kinds of historical actors, represented the particular characteristics and belief systems of the community in which the asylum was embedded.

Why did the British Government build these native lunatic asylums in India? Why wasn't there greater codification of the care and treatment of lunatics therein? How did a very European institution become such a fluid space, so steeped in local and indigenous

ideas? Ultimately, what do these permeable and hybrid spaces tell us about the social and cultural history of South Asia, and the ideology of the nineteenth-century asylum in this time?

Overview

This dissertation is set at the intersection of two fields of history that do not regularly interact. By combining the history of psychiatry with the history of colonial South Asia, this project examines the native lunatic asylum in India as a critically useful analytic lens that sheds light in both directions. The lunatic asylums of the mid-late nineteenth century were extraordinarily permeable spaces and allow us to examine multiple sites, multiple brands of colonial activity, on the ground. I argue this permeability was produced as a result of the disconnect between medical and judicial branches of government at the administrative level, and the inability to absolutely translate an institutional ideal that embraced only Western epistemologies of madness to the subcontinent. Whereas local men and women were also recruited to medical dispensaries and hospitals in India, these institutions already possessed a clear ideological doctrine, which meant that local ideas were less easily assimilated into everyday practice, as compared with the lunatic asylum. As such, native asylums in India reflected the concerns and priorities of their communities at each location in a way that other medical institutions in the subcontinent did not; through these asylums we can glimpse the everyday life of British and Indian people in this colonial world.

Beginning with the first set of pan-Indian lunacy legislation in 1858, this project traces the establishment of native lunatic asylums, which only tenuously responded to official rule during their first couple of decades. However, they began to lose their

permeability, the fluid way in which people from all social strata could enter and influence asylum practice within, as the government embarked on numerous interventions to consolidate the asylum network, such as an asylum-wide survey in 1868; parallel movements in the rise of university education in India and the professionalisation of psychiatry served to underline these government interventions by the turn of the twentieth century. Together, both Western psychiatry and British hegemony became aligned as they entered the native asylum, and this served to enforce the walls against multiple kinds of people and practices, rather than encouraging their mixing. Thus the walls of the asylum became less permeable, and the practices within became more opaque and rigid. By the twentieth century, at the close of this project, the native asylum had transformed into an institution that were more similar to its European counterparts than before, and more akin to the archetype of colonial power with which we are familiar. This transformation was underlined by a second set of lunacy laws in 1912, which represented a confident top-down colonial intervention into the care and treatment of Indian insanes under British rule.

Intersecting two historiographies

The history of India can complicate the historiography of the asylum. The lunatic asylum is often subsumed within colonial historiographies as simply another site in which Europeans implemented colonial power. As a mainstay of the history of psychiatry, the asylum has been a useful and yet limiting point of focus with which to examine madness and its practitioners. Prosaically, the asylum has provided the greatest historical record with which to trace the treatment of insanity. However, inherent to conventional histories of the asylum is the notion that psychiatry was the only paradigm practiced inside. Many

histories have overlooked the rich community of actors who occupied the asylum, and the influences they had on its daily practices, simply because they did not participate in psychiatric or ‘scientific’ discussions of insanity.

Starting with Erwin Ackerknecht’s and Gregory Zilboorg’s classic texts, up until Roy Porter’s monograph on the topic, historians of psychiatry and the mind sciences focused almost entirely on Western Europe and North America, until the 1990s.³ In part this was a legacy from medical history and the historiography of science: science and medicine were by definition a Western endeavour, thus to write a history of either beyond the West was somewhat meaningless. This was certainly true for the history of psychiatry: the term ‘psychiatry’ was coined by a German, Johan Christian Reil, in 1808, and was representative of a scientific rationality that could not be located elsewhere. Michel Foucault’s influential opus, *Madness and Civilization*, compounded the idea that psychiatry was purely a Western construct.⁴ This is not to say that Foucault did nothing to benefit the history of psychiatry. Power structures were important to unpacking the dynamics of professional psychiatry, and even though the native asylums of this project functioned differently from their counterparts in Europe, the Foucauldian assessment of power, knowledge and discipline is still a useful initial framework with which to assess the Indian context. For example, patients remained the objects of asylum care, whether that care was psychiatric, local or a hybrid of the two, and there is an argument to be

³ Erwin Ackerknecht, *A Short History of Psychiatry* (New York: Hafner, 1968); Gregory Zilboorg, *A History of Medical Psychology* (New York: W. W. Norton, 1967); Roy Porter, *A Social History of Madness: Stories of the Insane* (London: Phoenix Giants, 1996). The list of canonical texts in the history of psychiatry is too long to mention here: the entire corpus has its own Library Congress classification code (BF).

⁴ Michel Foucault, *Madness and Civilization: a history of insanity in the age of reason* (New York: Routledge, 1967).

made for how this treatment served to distance and reify the Otherness of those patients who seemed unfamiliar to the Indian actors in the asylum. For a long time, though, being unable to trace the origins of major psychiatric developments to anywhere except a few select places in Western Europe suggested that any psychiatric beliefs and practices outside the West did not warrant further investigation. This is a significant reason why the asylums in my project, which lacked discernible psychiatric foundations, have often been subsumed within histories of medical hospitals and colonial prisons.

The notion that asylums and professional psychiatry were bastions of state power was propagated by an entire generation of radical historians: Andrew Scull reinforced the notion of the asylum as an impenetrable and imposing prison, while David Rothman strongly argued that the insane asylum was borne in the same moment of institutional discipline as prisons and poorhouses in antebellum America.⁵ Later scholars, such as Nancy Tomes, Gerald Grob and Anne Digby, criticized the analytic with which these radical historians had framed the asylum, and interrogated a broader array of primary sources that painted a more nuanced history of madness; however, the historiographical preoccupation of the Eurocentric asylum and professional psychiatry remained.⁶ My project really challenges this idea, building on the work of recent historians of psychiatry

⁵ Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London; New York: St. Martin's Press, 1979); David Rothman, *The Discovery of the Asylum: Social Order and Disorder in a new Republic* (Boston: Little, Brown, 1971).

⁶ Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883* (Cambridge: Cambridge University Press, 1984); Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994); Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985).

who have begun to show how the category of asylum and of psychiatry can be reframed and used as an analytic in the pre-scientific and early colonial world.⁴

The history of the asylum, however, can also complicate South Asian historiography. It can be difficult to separate the political events of 1857-1858 from contemporary social or cultural events in India. The “Mutiny” was so much more than a military rupture, invoking so many changes in sovereignty, employment, agency and the colonial encounter, it is easy to make a causal argument for any developments in India at this time as being a consequence of these uprisings. Many imperial historians have considered the effect of this “historical rupture” on other aspects of Indian life: Eric Stokes is one of many who has placed the uprising in a larger context of British agrarian policy, while Gautam Bhadra, Rudrangshu Mukherjee and Tapti Roy have complicated the locus of conflict by exposing the variegated leadership of the rebellion in district-level and India-wide scholarship.⁵

As one of the best political and cultural histories of the 1857 revolt, Sashi Bahusan Chaudhuri has placed the events of 1857-58 in the context of civil unrest and conflict throughout the late eighteenth and early nineteenth centuries.⁶ This idea of “historical continuity” is one embraced by several other historians of the colonial

⁴ Christina Ramos, “Bedlam in the New World: A Colonial Hospital for the Mentally Ill in Mexico and its Patients, 1567-1821” (PhD diss., Harvard University, forthcoming).

⁵ Eric Stokes, *The Peasant and the Raj: Studies in Agrarian Society and Peasant Rebellion in Colonial India* (Cambridge: Cambridge University Press, 1978); Gautam Bhadra, “Four Rebels of Eighteen-Fifty-Seven,” in *Selected Subaltern Studies*, eds. Ranajit Guha and Gayatri Chakravorty Spivak (New York: Oxford University Press, 1988), 129-178; Rudrangshu Mukherjee, *Awadh in Revolt: A Study of Popular Resistance* (Oxford; Delhi: Oxford University Press, 1984); Tapti Roy, *A countryside in Revolt: Bulandshahr District, 1857* (Delhi: Oxford University Press, 1996).

⁶ Sashi Bahusan Chaudhuri, *Civil Rebellion in the Indian Mutinies* (Calcutta: World Press, 1957).

period.¹⁰ Ideologically, as Thomas Metcalf has shown, the new Government of India had a “hands-off” policy after 1858, especially when it came to the public realms of religion and custom.¹¹ However, in practice, the colonial state was as intrusive as it had ever been under the EIC: Surgeon-Major Frederic J. Mouat completed an entire institutional overhaul; the Indian army was reorganized to prevent sepoys from outnumbering British soldiers again; and the British government began a lengthy process of codifying categories of Indians, using terms such as “habitually criminal” in the Criminal Tribes Act of 1871, and religiously dividing India into “majority” and “minority” areas.¹²

The intrusiveness of the colonial state can be seen in its imposition of Western science and medicine after 1858: the Crown increased its public health efforts with vaccinations and attempts to contain the late-nineteenth-century plague epidemics.¹³ We can see the 1858 Lunacy Acts as part of this trend for increased intervention, but after the initial legislation, the first generation of native asylums were essentially left alone,

¹⁰ Christopher Bayly has argued that there was great continuity in economic structure and cultural collaboration from the time of the EIC to Crown rule: *Indian Society and the Making of the British Empire* (Cambridge: Cambridge University Press, 1988), 136-168.

¹¹ Thomas Metcalf, *The Aftermath of Revolt: India, 1857-1870* (Princeton: Princeton University Press, 1964), 92.

¹² Mouat was especially concerned with prisons and educational institutions. Ross Lawrenson, “Frederic John Mouat (1816-97),” *Journal of Medical Biography* 15 (2007): 201. See also, M. Mohar Ali, “Hunter’s ‘Indian Musalmans’: A Re-examination of its background,” *Journal of the Royal Asiatic Society of Great Britain and Ireland* 1 (1980): 35; and Crispin Bates, *Race, Caste and Tribe in Central India: The Early Origins of Indian Anthropometry* (Edinburgh: Centre for South Asian Studies, 1995). See Gopal Sarvepalli’s examination of the papers of the Indian Secretaries of State and Viceroy for evidence of very ‘hands-on’ policies after 1858: *British Policy in India, 1858-1905* (Cambridge: Cambridge University Press, 1965). See Ayesha Jalal for a thorough historical investigation of Muslim identity and politics at the transition from EIC to Crown rule: *Self and Sovereignty: Individual and Community in South Asian Islam since 1850* (New York: Routledge, 2002).

¹³ Mark Harrison, *Public Health in British India: Anglo-Indian Preventative Medicine, 1859-1914* (Cambridge: Cambridge University Press, 1994), 99-116; David Arnold, “Touching the Body: Perspectives on the Indian Plague, 1896 to 1900,” in *Selected Subaltern Studies*, eds. Ranajit Guha and Gayatri Chakravorty Spivak (Delhi: Oxford University Press, 1988), 393.

managed only by individual British superintendents at each site, with little knowledge of his peers in other asylums, and no real colonial agenda to impose. In fact, the new Government of India was not simply “hands-off” with its native lunacy project, it lacked any responsibility for Indian insanes and native asylums for almost a decade. Even though there was some continuity with the EIC’s social reforms from the earlier half of the nineteenth century, this delinquency of responsibility was very different from the policies the Crown had enacted as part of its imperial project to consolidate sovereignty.

The history of the asylum thus brings an argument for “historical continuity” and for “historical rupture” to the history of psychiatry in South Asia. As the first chapter will show, conversations about the need for native lunatic asylums predate the advent of Crown rule of India. The 1857-8 uprisings certainly flavoured the milieu in which native lunacy legislation was enacted, but the native asylum belongs to a longer history, a legacy of the EIC’s legislative process and an extension of the asylum reforms that had already occurred in Britain. This project advocates for the native asylum in India as being unexpected in light of the new Government of India’s sovereign goals, and also atypical, rather than archetypal, of the lunatic asylums being established elsewhere in this period of time.

An Archetypal Institution?

To appreciate the significance of the colonial asylum being atypical, we need to first understand the historiography that essentializes the asylum as archetypal. Where does this stereotype come from? Erving Goffman’s concept of the “total institution” is a foundation for this idea. His 1961 concept was useful because of how well it defined a

distinct set of organizations that, Janus-faced, both constituted and separated modern society. He wrote:

A total institution may be defined as a place of residence and work where a large number of like-situated individuals cut off from the wider society for an appreciable period of time together lead an enclosed formally administered round of life.¹⁴

For example, prisons and asylums in Western Europe and North America removed the barriers that usually separated the spheres of play, work and sleep, and enclosed all of these realms into one space. A total institution removed heterogeneity and imposed conformity. Goffman constructed this concept at a time where the historiography of asylums was still celebratory, linear and Whiggish. After he introduced this concept, historians of psychiatry countered the celebratory tone of asylum historiography and embraced the idea that asylums were total institutions, impenetrable fortresses that imposed one homogenizing idea. In the colonial context, this total impenetrability translated into colonial hegemony.

In the post-colonial context, Frantz Fanon's work was key to propagating an almost timeless idea about the brutal power of the colonial asylum. He believed that the colonies promised French psychiatrists an opportunity to recreate Philippe Pinel's well-documented 'liberation' of colonial insanes: physically liberating the madmen from the chains of their existence and enlightening their condition of life.¹⁵ Fanon witnessed the so-called emancipation of these insanes in 1908 via the extension of French culture via colonization. Because the mentally ill did not seem to recover, their physical chains were

¹⁴ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961), 11.

¹⁵ Frantz Fanon, *The Wretched of the Earth* (New York: Grove Press, 1965), 42.

in many ways replaced by the psychological chains of French racism, Fanon asserted that the mental hospitals of the French Empire amounted to nothing but “systematized dehumanization.”¹⁶

The colonial prison, in particular, strongly contrasts with the narrative I am suggesting of the colonial asylum. Anand Yang and David Arnold wrote some valuable early contributions to the literature on the colonial prison. Both rely heavily on Foucauldian paradigms of power-knowledge: Yang deftly suggests the government of India consolidated their authority by diverging from humane theories of punishment in Europe and instituting their own ‘science’ of punishment that was designed to attack the mind; David Arnold echoed Yang on the totality of prison control, demonstrating the coercive practices of a British government that was constantly in opposition to prisoners’ rights and religious requirements.¹⁷ Arnold’s view of the prison later became less totalitarian, when he framed the prison as an ethnographic laboratory, where multiple ideas about prisoner diet were discussed and negotiated. He asserted that the colonial prison “created an institutional and social space that was colonized by other, unofficial, networks of power and knowledge than those represented by formal authority.”¹⁸ Neither

¹⁶ *Ibid.*

¹⁷ Anand A. Yang, “Disciplining ‘Natives’: Prisons and Prisoners in Early Nineteenth Century India,” *South Asia* 10, 2 (1987): 31. David Arnold uses food as an effective example of the site of this power-play: “The Colonial Prison: Power, Knowledge and Penology in Nineteenth-Century India,” in *Subaltern studies VIII: essays in honour of Ranajit Guha*, eds. David Arnold and David Hardiman (New Delhi: Oxford University Press, 1994), 148-187.

¹⁸ David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 155.

Arnold nor Yang went as far as examining the everyday practice of prison management more closely, to explore evidence for a less totalitarian institution.¹⁹

Jonathan Sadowsky convincingly followed Arnold's work to show how the total asylum made its way to Africa, importing colonial medicine as part of Western imperialism. He argues that medical services were a major rationale for colonialism, and that hospitals and clinics were typically most developed when and where there was a medical threat to the local workforce. However, and this is where my project builds on his, colonial governments were also filled with more liberal voices, who argued that the state had an obligation to provide social services. It was for this reason that asylums were built, however inconsistent they might have seemed with the colonial goals of economic exploitation and hegemony.²⁰ For Sadowsky, the totalitarian nature of the asylum came from the hegemonic power of colonial psychiatry in the middle of the twentieth century; psychiatry was a forensic tool that went beyond the 'medical gaze' to discipline native peoples in a colonial world.

Historians of the lunatic asylum in South Asia are complicit in the construction of the colonial asylum as an archetype of power. Waltraud Ernst's pioneering work on the European insane in colonial India mapped out much of the initial terrain.²¹ Her main project in the 1990s propagated the idea that the total institutions of Europe performed

¹⁹ Benjamin Siegel is a historian who is invested in everyday experiences in the colonial prison, and has done some work to this end, using micro-contestations over food to reveal the constant negotiations between multiple actors in this type of institution. See "The Hungry State: Food and Nation-Building in India, 1943-1966" (PhD diss., Harvard University, forthcoming).

²⁰ Jonathan Sadowsky, "The Reality of Mental Illness and the Social World: Lessons from Colonial Psychiatry," *Harvard Review of Psychiatry* 11, 4 (July 2003): 91-112.

²¹ Ernst was particularly interested in the "politics of control." Waltraud Ernst, *Mad Tales from the Raj: The European Insane in British India, 1800-1858* (New York: Anthem Press, 1991), 98, 142-147.

the same role in the colonies, despite their being in a completely different climate. It is as a result of Waltraud Ernst's forays into psychiatry in South Asia that we have a great deal more knowledge regarding the location of archival and primary source material in the subcontinent, however her examinations of both European and 'native' asylums in the earlier colonial period relied a great deal upon the idea that asylums could only ever be measures of social control, both at home and in the colonies.²²

James Mills built on Ernst's work to alert us of a rich history of the native lunatic asylum in South Asia, temporally located after European settlement in the subcontinent but before the rise of a professional psychiatry. For Mills, the asylum as a seat of colonial power was also key. "Power is everywhere," he argues, but "attaching too much significance to naming it at any one moment obscures this fact."²³ He deftly asserted that the historical actors in Indian asylums were autonomous individuals whose actions could not be understood by historians simply in terms of prevailing structures of power, whether they were colonial, medical or otherwise. Mills can also be credited as being the first to suggest that lunatic asylums in India were not as dissimilar from European asylums as the Eurocentric historiography would suggest. However, his predilection for seeing all diagnoses through the lens of cannabis use, while novel, did more to obscure the role played by attendants and other subsidiary staff in the asylum. My project takes up

²² Alongside *Mad Tales*, for which she was highly praised, Ernst also produced a chapter on 'Native Lunatic Asylums' under the East India Company. She found "there was no mention made whatsoever of the Indian assistant's duties", which may explain why her work subsequently focused on only the European asylums, for which there exist more records. Ernst, "The establishment of 'Native Lunatic Asylums' in early nineteenth-century British India," in *Studies in Indian Medical History*, eds. G. J. Meulenbeld and D. Wujastyk (Delhi: Motilal Banarsidass, 2001), 180.

²³ James Mills, *Madness, Cannabis and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857-1900* (London; New York: Macmillan, 2000), 185.

where he left off, focusing less on the doctor and patient populations, and more on the kinds of ideology brought into the asylum by the surrounding community.

Sanjeev Jain, a psychiatrist from the National Institute of Mental Health and Neurological Sciences at Bangalore in India, has addressed the extent to which Indian and European concepts of mental illness ‘cross-fertilized’ in the later colonial period. Jain suggests that, at a theoretical level, by the end of the nineteenth century, Indian medical students were beginning to engage with English writings on psychiatry, which established points of contact between Indian and Western systems of madness. Some of these students later rose to become superintendents of asylums (or mental hospitals, as they soon became known) in the early twentieth century, and their notebooks and asylum reports detail the transition occurring between psychiatric frameworks within the colony. Using the community framework, my examination of these asylums locates this hybridity of ideas much earlier, and at a more domestic level, than Jain’s upper-class and upper-caste students experienced.

Comparisons with asylums in other colonial sites, while far removed from the Indian context, are useful in framing this dissertation. Mark Finnane has written one of the most comprehensive works on the development of asylum care in Ireland between 1817 and 1914. As in India, the British government in Ireland initially supervised and directed the establishment of over twenty new district asylums, but by the end of the twentieth century – recognizing growing fiscal burdens and a failure to align with a newly professional brand of psychiatry – authority was shifted to elected local governments.²⁴ As will be made clear in Chapters 4 and 5, local government had less

²⁴ Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (London: Croom Helm, 1981), 175-200.

involvement in the management of asylums by the twentieth century, as state government officials sought to train Indians and rigorously enforce Western psychiatric doctrine in order to offset the ‘native’ asylums’ problems in economy and identity. Finnane’s uncritical acceptance that the asylums were failures means all of the Irish asylums are treated as if they were homogenous, and his work stops at the level of administration, without examining these institutions at a granular level. In Finnane’s work, the British government’s initial direction colours his understanding of the asylum. It is perhaps not an archetype of colonial power, nonetheless the Irish asylum is painted as an effective tool for colonial hegemony.

Megan Vaughan was one of the first historians of colonial psychiatry to disavow the utility of applying Foucault to the imperial context by noting the lack of ‘great confinements’ in colonies.²⁵ In her later work, she has argued how distinctions between the mad and the sane, the normal and the pathological, were encapsulated within racial divisions: the color of one’s skin, blackness itself, became pathological in the colonial context.²⁶ While there were many more divisions of race and skin colour in colonial India, and the significant presence of multiple generations of Anglo-Indians prevented any absolute association between colour and behaviour, racial predisposition diffusely underpinned diagnoses and attitudes towards insanity in the ‘native’ asylum of India. The science of phrenology was influential enough to imagine some inherent difference between Indians and Britons: skull shape and personal ability were thought to be

²⁵ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991), 17.

²⁶ Megan Vaughan, “Introduction,” in *Psychiatry and Empire*, eds. Sloan Mahone and Megan Vaughan (New York: Palgrave Macmillan, 2007), 1-16.

correlated, and this association did not disappear entirely with the demise of phrenology as a 'real' science.²⁷

David Wright, in contrast, has done a great deal of work to examine Canadian asylums at the granular level. His work critically re-examines historians' assumptions about the social role of asylums in the nineteenth century by separating the history of confinement from the history of psychiatry, and showing that families, rather than asylum doctors, were critical to asylum admission.²⁸ He twists the conventional Foucauldian trope of asylums as sites for state-based social control to suggest that the confinement of the insane was a strategic response of households who were trying to cope with the new stresses of industrialization, not a consequence of a professionalizing psychiatric elite. Wright asserts that a "psychiatric gaze has transfixed a generation of scholars" so that it is difficult to write a history of the asylum without simultaneously writing a history of psychiatry, but the separation of these two subfields allows us to construct a colonial asylum that is not underlined by the hegemonic potential of colonial psychiatry.²⁹

My work draws strongly on the work of Wright and Vaughan to explode the notion of the asylum as simply a conduit for power. In fact, I have located a history that situates the colonial asylum as far removed from the hegemonic asylums in Europe and other institutions in India, such as the prison, which more clearly embodied a discernible colonial purpose from the nineteenth century onwards.

²⁷ Kim A. Wagner, "Confessions of a Skull: Phrenology and Colonial Knowledge in Early Nineteenth-Century India," *History Workshop Journal* 69, 1 (2010): 27-51.

²⁸ David Wright, "Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century," *Social History of Medicine* 10, 1 (1997): 137-138.

²⁹ *Ibid.*, 139.

An Atypical Institution

The history of colonial psychiatry is a useful intervention in the history of colonial India because of its ability to reframe the asylum as an analytical lens that can shed light on the everyday social interactions of mid-century India. With this methodology, the asylum ceases to be a derivative of the hospital and the prison and exhibits the interactive and heterogeneous tendencies of the Company barracks or early education system. Similarly, the history of colonial India is a useful intervention in the history of psychiatry because of its ability to take the conventional narrative of the oppressive lunatic asylum and transform it into an unfamiliarly interactive space.³⁰ The combination of both historiographies suggests that the colonial asylum can be an atypical institution, neither a subsidiary of other institutions nor an archetype of colonial power. This project makes an argument for analytically useful permeability, a hybridized system of practice and a sociology of space by drawing on a number of historical ideas.

Mark Harrison has written about the need to use one constant, such as the medical hospital, to examine colonial institutions in different settings.³¹ He writes, “medical hospital practices had multiple origins... some of the features of what Michel Foucault dubbed clinico-anatomical medicine were flourishing in the European colonies some years before they appeared in revolutionary Paris.”³² We can use Harrison’s article to inform our examination of the colonial asylum in British India: native asylums were also

³⁰ Steven Shapin once commented that the ultimate goal of history should be to make the familiar unfamiliar, and render the unfamiliar as something familiar. I attempt to make the asylum an unfamiliar space, while rendering the ‘Otherness’ of the colonial environment as very familiar for the Western scholar.

³¹ Mark Harrison, “Introduction,” in *From Western Medicine to Global Medicine: The Hospital Beyond the West*, edited by M. Harrison et al. (New Delhi: Orient Blackswan, 2009), 3.

³² *Ibid.*, 6.

established as a result of multiple systems of welfare and ideas about the Indian mind. The asylums in this project followed some of the practices observed in European asylums but they also incorporated local ideas about insanity, in an interaction that was not permissible in their European counterparts. The asylum shows that, in different parts of India, local knowledge was being considered in equal parts to Western psychiatry. Using the lunatic asylum as our methodological constant, we can use location in India as a variable to ‘test’ and evaluate Indian and British cultural responses to it.

David Arnold has argued a similar point with regards to cholera in colonial India. Borrowing from Charles Rosenberg’s seminal work, Arnold shows how the “individuality of disease entities” can be understood best in the colonial Indian context when we compare the different responses to the disease across India.³³ Cholera’s ubiquitous penetration of all levels of society, European and native, allows us as historians to view responses to the disease epidemics with interest, as it affected the poor, the privileged and vast landscapes of rural India in ways that many structures of British imperialism could not. In this way, cholera provides a convenient point of entry for the study of the mentality and material conditions of India’s wealthier and subordinate classes.³⁴

While mental diseases were not seen in the same light as bodily epidemics such as the plague or cholera, they were ubiquitous in afflicting members of all classes in India, not just the poor or lower castes. There was no such thing as a lunacy epidemic, however the presence of all castes and types in the native lunatic asylum (even women and

³³ Charles Rosenberg, *The Cholera Years: the United States in 1832, 1849 and 1866* (Chicago: University of Chicago Press, 1962), 40-54.

³⁴ David Arnold, “Cholera and Colonialism in British India,” *Past and Present* 113, 1 (1986): 149.

Brahmins) suggests that we can use the individuality of lunacy in the same way that Arnold and Rosenberg have used cholera. Although none of the sources or asylum superintendents provided a coherent definition of lunacy in colonial India, it was nonetheless recognized as an affliction of some sort.³⁵ Tracking Indian and British attitudes to lunacy, over time and space, is a remarkably effective way to track the social and cultural life of British India. Some common understanding of lunacy, regardless of its hybrid nature, provided the impetus for British and Indian men and women to inhabit the asylum. As such, I will refer to lunacy throughout this project, but will not restrict my meaning to any particular definition.

The potency of lunacy as a disease entity is not the only way in which the asylum has analytical utility. The social history of the asylum reveals a granularity that can often be obscured by a singular fixation with one brand of psychiatry, or asylum practice, in the historiography. This granularity has been exposed in historical analyses of other kinds of institutions. For example, Clare Anderson has dealt with the cultural economy of prisons from two perspectives: in “Fashioning Identities”, she showed how the attire associated with being incarcerated was key for the British government’s colonial surveillance imperatives (with prison garb becoming the foundations of the creation of new ‘criminal’ caste categories), while in her longer monograph, *Legible Bodies*, she extended this argument to show how colonial prisons literally imprinted their dominance using

³⁵ The asylum superintendents’ knowledge and understanding of lunacy comes out of an important survey, which forms the foundations of my discussion in Chapter 3. The superintendents are the most visible manifestation of the multitude of psychiatric and non-psychiatric ideas that filled these asylums. Not only did they have wildly different ideas about how to treat Indian insanes themselves, they also fostered the fluid and hybridized interaction of belief systems within their individual institutions.

tattoos.³⁶ Anderson's monograph does a lot of work to show how the colonial prison's power went beyond the physical structure, and into the everyday social and cultural lives of British Indians, with a granularity that I hope to bring to my work on the colonial asylum. While some historians of psychiatry have looked at the asylum in this light, few have taken advantage of the usefulness of the asylum for larger histories of South Asia.

Intelligent comparative work in the imperial world is still needed at the risk of losing British India's remarkable heterogeneity in macro-studies of the subcontinent. Maya Jasanoff's excellent empire-wide comparison of the imperial collectors in the late eighteenth century is one example of transnational comparative history done well: the madness of elite men who travel the world to collect valuable and vulnerable items is a metaphor, a nuanced explanation of colonial development in multiple sites within a nascent empire.³⁷ Such a novel revisionist history is difficult to translate to the 'native' asylum in India, where there were few singularly rich or revolutionary men to compare between institutions. However, Jasanoff's arguments for porosity and fluidity, both ideological and physical, are integral to this project. Rather than an elite young man's eighteenth-century collection, I am using the notion of multiple asylum communities to think carefully about how ideas and people moved fluidly within the latter half of nineteenth-century India.

³⁶ Clare Anderson, "Fashioning Identities: Convict Dress in colonial South and Southeast Asia," *History Workshop Journal* 52 (2001): 153-174. In her explication of the forms of dominance that made Indian bodies legible and docile in colonial India, Anderson suggests that the geographical location of India (coupled with its interactions with the East and West throughout history) permitted the construction of a society whose bodies could be 'read' by British colonizers in a particular way. Anderson veers away from a teleological explanation for India's history of colonization, and her arguments offer a fresh perspective on the way that we write history. Clare Anderson, *Legible Bodies: Race, Criminality and Colonialism in South Asia* (Oxford; New York: Berg, 2004).

³⁷ Maya Jasanoff, *Edge of Empire: Conquest and Collecting on the Eastern Frontiers of the British Empire, 1750-1850* (New York: Alfred A. Knopf, 2005).

Asylum as Ecology: An Interactive Space

My project suggests the native asylum was not a typical colonial institution, as it did not exert hegemony on behalf of the colonial state. It was a permeable space, with fluid peripheries and a hybridized practice of care within.

Hybridity is one of the most disputed terms in post-colonial studies, due to its invocation of racism. ‘Hybridity’ commonly refers to the creation of “new transcultural forms within the contact zone produced by colonization.”³⁸ While hybridity can take many forms – Creole is a good example of linguistic hybridity – this project deals with the notion as a point of informal knowledge production in the colonial asylum. The psychiatry, or even ‘proto-psychiatry’, that was practiced at each asylum was shaped and reformed by local belief systems that were specific to the men and women who regularly transitioned into and out of the asylum at a particular site. As psychiatry was not a fortified or clearly delineated discipline in the 1850s and 1860s, its presence in the native asylum was vulnerable to alternative modes of treatment as per the heterogeneous population who inhabited it.

Robert Young has remarked on the negativity often associated with this term: writing more generally on imperialism and post-colonialism, he argues that “hybridity” was influential in imperial and colonial discourse by giving damaging reports on the union of different races.³⁹ However, the exchanges, the flows of knowledge and the negotiations of asylum practice, did not occur uni-directionally in the lunatic asylums of

³⁸ Bill Ashcroft et al., *Post-Colonial Studies: The Key Concepts* (London: Routledge, 2003), 118.

³⁹ Robert Young, *Colonial desire: hybridity in theory, culture and race* (London; New York: Routledge, 1995).

India. Bill Ashcroft counters Young's claims, suggesting that hybridity, especially in the post-colonial world, was a cultural strength. "It is not a case of the oppressor obliterating the oppressed, or the colonizer silencing the colonized" – in practice, as we see in the asylum, hybridity was about creating a system that suited the function of its community, and drew strength from the heterogeneity of its participants.⁴⁰ Chapter 2 will illuminate the heterogeneous bi-directionality of the Indian lunatic asylum and show how this reinforced what I call the 'ecology' of the asylum.

My intervention is reliant upon the extraordinary permeability of the asylum as an institution and as a community. As a variety of Indian and British actors become visible as constituting a rather heterogeneous space, I will intimate the presence of a hybridized system of treatment that borrowed from local, state and colonial beliefs about madness. I am concerned with those actors who are traditionally left out of the asylum records: asylum attendants, families and local community members, but I am also interested in revealing the way some popular historical actors, such as asylum superintendents, participated in these interactions. The presence of non-traditional asylum actors allows me to argue for the permeability of the native lunatic asylum in India, and for the utility of the asylum as an unexplored lens for mid-century South Asian history.

The framing of these familiar and unfamiliar groups of actors is important. I want to represent the changing permeability of the asylum, and not distinguish between 'inside' and 'outside' the asylum. The notion of a community that extends across the

⁴⁰ Ashcroft recently argued that the writing of history by a hybridized culture in the post-colonial world is a method of reappropriating a past that was oppressed by the dominant culture. Bill Ashcroft, *Post-Colonial Transformation* (New York; London: Routledge, 2013), 102.

asylum walls is ideal, but the term ‘community’ comes with its own problematic set of meanings.

An ecological definition of community speaks to a desire to remove essentializing tendencies and understand a broader, more holistic concept of the asylum, whereby all the objects, animate or no, fit together in an organic, ever-changing, amorphously bound entity. Each human actor does not necessarily have knowledge of every part of the ecological environment, and not every kind of actor is visible in each asylum. However, multiple communities intersect within the ecology of the asylum, and this intersection allows us to draw richer conclusions than if we were bounded by a strict delineation of an asylum community. This model has been used by environmental historians such as William Cronon, who sought to write a history of neither Chicago nor the Great West, but the relationship between them, in a way that would present economic and environmental history as a unified narrative.⁴¹ Similarly, this dissertation is neither a history just of the native asylum or of colonial India, but a hybrid story about the relationship between and development of both.

What exists in this ecological community? Based on its primary function, there were native patients and British doctors in every ‘native’ asylum. Each asylum was assigned a superintendent, and there were also Official Visitors, men or women from the government who – along with their other responsibilities to the Crown – visited a particular asylum up to four times a year to check on its functioning. In contrast to the official visitors, there were native medical assistants, who had no official training, but received a small wage to assist the British doctors. Beyond these official members, the

⁴¹ William Cronon, *Nature's Metropolis: Chicago and the Great West* (New York: W. W. Norton & Company, 1991), 10-13.

asylum employed many non-medical personnel. These included cooks, cleaners, laundry men (dhobis), janitors, security men, and male and female attendants. These actors did not live on site in the asylum (although some of them may have slept overnight when acting as night attendants), but would have lived in the surrounding village or town, within close walking distance. On top of these regularly employed natives, the asylum embraced more disparate groups: tea sellers (chai wallahs), for example, who visited on an ad hoc basis, and missionaries or religious gurus, all of whom had their own schedule, and payment of some type was expected afterwards. Finally, there were the patients' families, whose frequency of visitation depended on the nature of the familial relationship. Some patients had very concerned families and relatives in the asylum's immediate vicinity, who visited them almost daily, with food, gossip and care. Other patients, having been picked up, wandering the countryside, with little recorded family history, never received guests at all, unless mistakenly.⁴²

The variety of people, and frequency with which they entered and exited the asylum, allows us to extend the rubric of the native asylum to large swathes of nineteenth-century India. The informality and mundane nature of many of their visits belies the significance of their movements: the asylum did not exist, as it had done in many places in Western Europe, as an isolated and impenetrable monolith of Western psychiatry. The colonial asylum in nineteenth-century India was fully integrated into the social, political and economic world. This particularly colonial quality, as seen in Indian asylums but not in other asylums at this time, provides us with an unusually acute vision

⁴² British record-keeping, though fastidious, had not developed a system that distinguished between lots of brown people, with dark hair and dark eyes -- this is the land which birthed fingerprinting as a way of distinguishing between such similar-looking people. Simon A. Cole, *Suspect Identities: A History of Criminal Identification and Fingerprinting* (Cambridge: Harvard University Press, 2001), 60-96.

of everyday life that is not explored in the historiography for psychiatry and has not been explained in South Asian literature either. While the interactions varied based on the specific location of each asylum, we find that the ecology of each institution is a useful lens with which to examine the everyday fabric of India under British rule.

Concerns and Privileges

Scholars in the early subaltern studies school attempted to turn away from the historiographical tradition of the elite perspective by privileging the least powerful voices, of the lower castes and classes in India, asserting a sense of identity and agency for millions of Indians.⁴³ This dissertation is not interested in essentializing subaltern agency or does it reifying the power and authority of elites in South Asia; rather, I suggest that there were significant changes in this period, occurring at the level of what political anthropologists have termed ‘popular politics.’⁴⁴ These changes impacted every level of Indian social life, including the elites, the Anglo-Indians, the middle-classes and the untouchable castes. To address the influence of these changes, the project privileges one kind of lens. The ‘lunacy’ label worked to dissolve the apparent hierarchies within communities, for all classes and castes were vulnerable to insanity; an ecological perspective of the asylum allows us to see these people and those who were not the direct recipients of asylum care, including doctors, attendants, villagers and families, all of whom participated in life within and without the institution.

⁴³ A successful overview of the evolving factions of the subaltern tradition is given in David Ludden, *Reading Subaltern Studies: Critical History, Contested Meaning and the Globalization of South Asia* (London: Anthem, 2002).

⁴⁴ Partha Chatterjee, *The Politics of the Governed: Reflections on Popular Politics in Most of the World* (New York: Columbia University, 2004), 14. The major criticism of this text is its analysis of India as representative of the world. However, coming out of the subaltern tradition, Chatterjee gives multiple political agencies to those existing outside of the formal structures for governance.

To access the voices of so many non-elite actors, we have to read against the dominant voice of asylum records and official reports. Local and non-imperial voices may also be accessed through the vernacular press, personal correspondence, biographies and memoirs.⁴⁵ Some of the following chapters layer a mixture of these sources to access the voices of multiple actors, elites and non-elites, while other chapters focus more on particular kinds of sources (such as the survey in Chapter 3) to examine the significance of a single group of actors more closely. Using a term such as ‘ecology’ rather than the physical limits of the asylum permits a conversation about a more dynamic interaction between all actors. Considering all the spaces suggested by the ecology of the asylum allows each community of actors to reveal different experiences and kinds of knowledge, which we can use to reveal a richness of detail at the ground level and in the colonial administration above.

There are problems with the use of the term ‘community’ by itself. An anthropological definition would look to delineate this project by a group of people who self-identify as belonging to each other, using the lens of ethnographic fieldwork.⁴⁶ In this dissertation, I cannot vouch for such self-identification. The asylum itself was sometimes referred to as a lunatic asylum, an insane asylum, and later a mental hospital, as well as a variety of other vernacular terms. To account for the variance in these terms would require a different project that removed the regional variation altogether, and

⁴⁵ Taking the vernacular press seriously is something that has been suggested by Kavita Sivaramakrishnan, *Old Potions, New Bottles: recasting indigenous medicine in colonial Punjab (1850-1945)* (New Delhi: Orient Longman, 2006), 53-86.

⁴⁶ Bernard Cohn wrote extensively about the practices and intentions of anthropologists and historians in their scholarly goals, especially the epistemological overlap between the two disciplines and how each field might borrow, beneficially, from the other. For example, see “History and Anthropology: State of Play”, *Comparative Studies in Society and History* 22, 2 (1980): 198-221.

completed a more conservative case study of each institution in turn. The multitude of names for the native asylum belies a cogent self-identification process within the asylum community. Many of my actors were voiceless in the historical record, and many were probably also voiceless during their own lifetimes, under the British colonial regime. Many identified with a particular group of actors or a singular community, and the ecology of the asylum allows me to examine multiple communities interacting in one hybrid site.

Medieval Latin saw ‘community’ concretely as *universitas*, as a body of fellows or of fellow-townsmen. Old French also defined ‘community’ as a sense of feeling, a fellowship of relations, shared by many or all. In the asylums in British India, there was no ‘common language’ between all the actors. The men and women who entered the asylum spoke a variety of languages, and some -being patients, who were very ill- spoke in unrecognizable tongues. Such a definition also does not allow for those actors who, without even entering the premise of the asylum, were still actively involved in discussing, knowing and managing the colonial asylum: those family members who stayed at home, or the administrative secretaries in the metropolises.

Yet another grouping technique could arise from Michel Callon and Bruno Latour’s model of actor-network theory (ANT).⁴⁷ This definition would include all the actors already mentioned and imbue the asylum itself (the walls, the beds, and the food) with agency as a significant actants in this history. The asylum certainly is a Latourian “non-human actor,” a real and material space around which a local world gathered to

⁴⁷ Latour reflected on ANT and its challenges in a 1996 article, entitled “On actor-network theory. A few clarifications plus more than a few complications,” January 1997. Retrieved June 8, 2013, from *Nettime*: <http://www.nettime.org/Lists-Archives/nettime-l-9801/msg00019.htm>.

form some kind of knowledge out of nature.⁴⁸ Despite the pioneering and valuable methodology inherent to ANT, this definition is too inclusive. Naturally, the buildings and the objects within that space provide useful and valuable facets of this history; however, I cannot in good faith lend equal agency to inanimate objects as to people, when so few of these actors were afforded a voice during their own lifetimes.⁴⁹

In the history of psychiatry, too, the notion of a community is problematic. The term invokes the notion of a ‘therapeutic community’ setting, akin to the community movement of the late twentieth century in North America and Europe. The Community Mental Health Center system arose in the 1960s, coincidentally at the same time as Goffman and others were eschewing the total institutions of the past, as an alternative to the confinement of individuals in state lunatic hospitals. This movement retrospectively tried to stake a claim upon the Belgian community model at Gheel and advocate deinstitutionalization.⁵⁰

My use of ‘asylum ecology’ permits the examination of communities that intersected with and at the asylum, without bringing the loaded nature of the term

⁴⁸ Bruno Latour, *Pandora's Hope: Essays on the Reality of Science Studies* (London: Harvard University Press, 1999), 303.

⁴⁹ I am entirely motivated in this statement by Andrus Pork's examination of the Soviet philosophy of history. Pork focused predominantly on the use of ‘direct lies’ and ‘blank pages’ to make historical arguments. Moreover, he strongly advocated for historical accountability and the need to be morally responsible for the arguments one chooses to privilege. See “History, Lying and Moral Responsibility”, *History and Theory* 29, 3 (October 1990): 321-330. A similar argument for historical responsibility is put forward in Chitrlekha Zutshi, “Debating the Past: Academic and Popular Histories of India,” *Perspectives on History* 47, 9 (December 2009), accessed September 11, 2013, <http://www.historians.org/perspectives/issues/2009/0912/0912Int1.cfm>.

⁵⁰ Murray Levine, *The History and Politics of Community Mental Health* (New York: Oxford University Press, 1981), 194-206. For a retrospective claim of Geel, see William L. Parry-Jones, “The Model of the Geel Lunatic Colony and its Influence on the Nineteenth-Century Asylum System in Britain,” in *Madhouses, Mad-Doctors and Madmen*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 201-217.

‘community’ and without drawing rigorous lines around the groups of actors I explore. I am showing that, far from Goffman’s total institution, historically the asylum was not simply a set of buildings that confined the patients and staff who worked inside it: the asylum was a complex structure, whose buildings and actors were embedded in a larger ecology. It is this fluid ecological model, embracing a multitude of treatment and care systems, that is neglected in so many histories of the asylum.

One of the few criticisms of this work, as with other histories of the colonial asylum is that the actual patient remains a fairly elusive and abstract entity. While lunatics generated a mass of legal, administrative and medical documentation unrivalled in most areas of government provision, we have very few personal accounts from the people who were the subject of these provisions. As a result, this project can only indirectly account for the individuals who made up these patient populations. However, this weakness is compensated by the extraordinary detail I do provide with regards to the community members who inhabited the asylum and participated in its practice. There is still much to be said on the internal arrangements and practicalities of asylums, in India and elsewhere, and this dissertation widens the opportunities to do so.

Perhaps it is better to suggest this project is less of an intervention but more of an opportunity for scholars in multiple fields of history to engage with each other and borrow analytical tools from their respective disciplines. In this way, the hybridity of my asylums is reflected in the layering of my methodology. Reading the asylum reports in parallel with mid-century political documentation, judicial proceedings, and micro-histories of a variety of institutions allows me to connect the historiographical traditions detailed earlier to reveal a richer understanding of the asylum and British India in the

second half of the nineteenth century and the first decades of the twentieth. The way in which the primary sources were categorized in the archives confirms a space between these scholarly traditions.⁵¹ It is my hope that this project can overcome this separation.

Chapter Overview

In what follows, I track different facets of the native lunatic asylum over time, starting with the 1858 Lunacy Acts and finishing with the more assertive 1912 legislation. This dissertation reveals an interesting trend: these asylums started ideologically fluid spaces, steeped in the local community, but became less permeable and more rigorously colonial over five decades. The native asylum was not derivative of the other colonial hospitals, prisons and schools that the British had used to contain and know their subjects for so long. Instead, these asylums reveal a very specific interaction between Briton and Indian in the nineteenth century: native minds and bodies were complicit in the production of colonial knowledge. There were literally communities of local Indian men and women actively involved in the daily management of lunatic asylums in India. The permeability of the colonial asylum means that we can use the institution as a lens that shows a brand of indigenous culture and treatment unique to each site.

The first chapter describes ideas and practices that made up a heterogeneous environment in the middle of the nineteenth century. This environment permitted the enactment of the first pan-Indian lunacy legislation, but it also allowed the creation of localized asylums that would be left, untouched by government intervention, for a full

⁵¹ While the Annual Reports for the asylums are archived under the reports for medical hospitals and vaccination clinics in India, requests for patient transfers, patient admissions and attendant recruitment are filed under the judicial proceedings along with information pertaining to the Lunacy Acts.

decade. This is an argument for complexity. The tenor of the asylum could have been remarkably different if any number of ideologies – colonial rule, psychiatry, subaltern resistance, local taboos – had been more rigorous. However, the social and cultural uncertainty provided by the transition from Company to Crown rule meant that these asylums were established without a coherent set of rules. Lunacy legislation had long been in the works: asylum reform in England, and education and prison reform in India, were both in effect before 1857 and 1858. Cultural legacies, such as the ruler's obligations as detailed in the *Arthashastra*, and the pre-history of asylums in India were also large factors in local communities' quick acceptance of these novel institutions. However, far from this being just an argument for continuity, the establishment of a new Government of India was a catalyst in one respect: the Raj had the money to fund these charitable institutions, and the impetus to quickly establish pan-Indian institutions for the consolidated care of Indian insanes.

The second chapter moves from a story of multiple origins to inspect the hybridity of everyday life and practice in the asylum. By practice, I mean any kind of care given towards the patients, be it dietetic, humoral, occupational or drug-based. I describe an entire world of mundane and essential interactions: between patients, attendants, community members and official visitors. The notion of an asylum community allows us to dissolve many preexisting boundaries between 'colonizer' and 'colonized'. The asylum was not only accepted by the local community, it was in many ways necessary for the local community, who were able to profit in terms of employment, trade and refuge (literal asylum). There was not a coherent therapeutic agenda, but there was a level of comfort and conviviality amongst the asylum community, which went far beyond the

goals of the state government, who seemed abstract and far removed. The asylum reports show very little evidence of stigma, neither by the local community nor the British staff. This is not to glorify the asylum, and suggest that there was no conflict, that this was some kind of colonial utopia. Rather that the popular themes of stigma, power, divisiveness and opacity were not as manifest as they were in other institutions that embraced clearly defined colonial doctrines, such as medicine in the colonial hospital. In fact, by allowing for good-natured conviviality in the historical record, we can make visible a number of actors who rarely appear in the historical literature: tea sellers, laundry men, local merchants in the bazaar, and asylum attendants.

The third chapter examines the first intervention by the colonial government after ten years of this kind of fluidity across the asylum walls, and the interactive modes of care inside the asylum. The 1868 survey was distributed to all asylum superintendents as a state effort to narrow down and enforce colonial authority in the native asylum. It suggests a remarkable ignorance by the government of these spaces prior to 1868, and an embarrassing inability to impose any coherent medical, colonial or scientific doctrine even at this point. The survey data by itself is interesting to a point: we see the hybridity of asylum practice reflected in the medley of responses that were returned. However, the most interesting part of the survey is the visibility it gives to asylum superintendents. Colonial asylums were not considered prestigious spaces, yet they had to be managed by some representative of the colonial government. The survey reveals these undistinguished men who ran rather undistinguished institutions, with very little support from their government, and very few tools to organize themselves into a profession. They were far removed from their counterparts in Europe, for they failed to produce any publications or

climb the colonial ladder. In revealing these undistinguished men, the 1868 survey also shows how we as historians can use historical surveys more broadly. This chapter thus connects to a larger history of surveys, surveying and surveillance, the most significant aspect of which is the birth of the Indian Census.

The fourth chapter uses the 1861 Indian Penal Code, the amendments to the Lunacy Acts in the 1880s, and the administrative transference of the lunatic asylums from the judicial to the medical branch of the government to show the increased attempts by the government to exert some kind of authority over these still-permeable spaces, which only tenuously responded to colonial structures above. The number of administrative and legal attempts at intervention is telling: after the 1868 survey, it was clear the colonial asylums were in want of a uniting framework, especially if they were to become cost-effective assets to the colonial imperative. However, the still-fractured condition of the colonial government prevented such unity or coherence, until at least the end of the nineteenth century. A new generation of asylums were established in this latter period, not as rashly as the first generation, and with less of the ideological and administrative ‘space’: they recruited superintendents with some experience of psychiatry or asylum medicine, or both, and the government took their advice with regards to asylum architecture, too. Suddenly, the appearance of the ‘native’ asylum looked more in keeping with the appearance of their European counterparts. They continued to permit some members of the local community, such as the tea sellers, but attendants and cooks no longer had the authority (or audacity) to make vocal their concerns about the treatment of the insane, especially when faced with a more coherent practice of psychiatry in the asylum. By contrast, the asylum superintendents found themselves acquiring the status of

a medical expert: their expert opinions were called upon in the court-room, and they established greater correspondence with each other.

The fifth chapter uses the 1912 lunacy legislation to highlight the massive transformation of the 'native' lunatic asylum in India, both on the ground and in the administration. This legislation finally consolidated and unified the processes by which Indian insanes were diagnosed, admitted and treated within each of the asylums across India. Insanes were less likely to be transferred to prisons, hospitals or even other asylums once admitted to a nearby institution, and there was a great deal more professionalism in lieu of conviviality between the asylum staff. To a great part, this was because of the success of medical education and British-style universities in India, which had trained local Indian men in Western medical practices, who brought these ideas into the asylum. No longer were there untrained attendants and cooks voicing their opinions; instead, we see a more homogenized, unified and self-identifying professional group of practitioners, who were far removed from the communities surrounding each institution. This is an argument for the significant role that native men and women played in determining the nature of the lunatic asylum: in 1858, a hybrid population of locals inhabited the asylum, but by 1912 only Western-trained actors were allowed (except for patients, of course). This reinforced the walls of the asylum, removing it from local culture, and creating a space that was entirely responsive to the imperial goals of the colonial government. Moreover, as the British Empire at large began to build colonial asylums in their new territorial acquisitions in the twentieth century, the impetus to fund and consolidate a system of psychiatric care in India underlined the impervious nature of the asylum.

Chapter 1: 1858: The First Native Lunacy Acts in India

The year 1858 is significant in South Asian history for many reasons. It marks what some scholars have called a “rupture” in the way Britain viewed its most valuable colony. It represents a moment that has been well documented by South Asian historians, but less so by historians of medicine: the end of the 1857 and 1858 uprisings, and the start of direct Crown rule, by the Queen of England.⁵² For the purposes of this project, however, 1858 also marks the year that the first pan-Indian asylum legislation was published, to manage lunacy in the subcontinent and direct the treatment of ‘Indian insanes’.

The bill for a new, Crown-officiated Government of India was passed on 2nd August 1858, disbanding the East India Company and placing India directly under British Rule.⁵³ Six weeks later, on 14th September of that year, the Government of India passed the three lunacy acts, the first acts to deal with native insanity across India:

Act XXXIV of 1858 – The Lunacy (Supreme Court) Act
Act XXXV of 1858 – The Lunacy (District Courts) Act
Act XXXVI of 1858 – Lunatic Asylums Act.

Together, these acts established lunatic asylums for natives, made “provision for better care” of lunatics, and codified the procedure for admitting insanes to these institutions. The word “lunatic” was to mean “every person found by due course of law to be of

⁵² Indirect rule is the term used by imperial historians to describe the East India Company’s system of subsidiary alliances in the Indian subcontinent. The Princely States under the EIC had been subject to British control, but local rulers retained their traditional administrative authority and ability to legislate. Michael Fisher, *Indirect rule in India: Residents and the Residency System, 1764-1858* (Delhi: Oxford University Press, 1991). Since the 1970s, scholars have problematized the direct-indirect rule dichotomy, arguing that, in practice, the perception of indirect rule was sometimes promoted to justify direct rule structures. Jonathan Derrick, “The ‘Native Clerk’ in Colonial West Africa,” *African Affairs* 82 (January 1983): 61-74.

⁵³ Government of India Act, 1858 (21 & 22 Vict. c. 106).

unsound mind and incapable of managing his affairs”.⁵⁴ The Lunacy Acts of 1858 were part of a general reorganization of institutions in India, and the building of these asylums was accompanied by a multitude of other colonial imperatives: the reorganization of the British Indian Army, the construction of universities and the establishment of the Indian Penal Code.⁵⁵ The new Government of India sought to consolidate and centralize the bureaucratic administration of their new colony. Such consolidations merged the British Crown with the old sovereign courts, and borrowed heavily from civil and criminal law in England. Within this broader context of colonial reform, the 1858 Lunacy Acts were established.

How might we explain asylum reform in India? In this chapter I will argue that the lunacy acts themselves were a direct consequence of asylum reform occurring in Britain at this time, and not borne of the new Government of India. In fact, there had already been discussion under the East India Company of the necessity to administer asylums for natives, well in advance of 1857 and 1858. Tracing their lineage further back, the lunacy acts in India clearly came out of the 1845 and 1853 Lunatics and County Asylums Acts that had preceded them in England.⁵⁶ Asylum and pauper reforms in

⁵⁴ Jivan Krishna Ghosh, *Probate, Minority, Lunacy and Certificate Acts containing Minors' Act XL of 1858 as affected by Acts XIV of 1870, IV of 1879; Minors' Amendment Act IX of 1861; the Curator's Act XIX of 1841; the Madras Minors' Acts XXI of 1855 and XIV of 1858; the Bombay Minors' Act XX of 1864; the Lunatics' Act XXXV of 1858; the Probate Act V of 1881 as amended by Acts VI and VII of 1889; and the Succession Certificate Act VII of 1889 - With the latest amendments on all acts and with copious notes of decided cases up to November 1889; and a Full Index* (Calcutta: J. Haldar & Co., 1890), 79.

⁵⁵ Robin J. Moore, “Imperial India, 1858-1914”, in *Oxford History of the British Empire: The Nineteenth Century*, ed. Andrew Porter (Oxford University Press, 2001), 422-446.

⁵⁶ The Lunatics Act of 1845 (8 & 9 Vict., c. 100) and the County Asylums Act of 1845 were passed through Parliament simultaneously, consolidating lunacy laws in England and Wales for the first time. In 1853, a new County Asylums Act was passed, which repealed the two 1845 acts. Bill Forsythe et al., “The New Poor Law and the County Pauper Lunatic Asylum – The Devon Experience, 1834-1884,” *Social History of Medicine* 9, 3 (1996): 335-355.

Britain had worked well to quell the British public's angst about over-population, overcrowding and the inhumane treatment of the 'uneducated masses' back home; there was no reason that similar reforms would not quell concerns about the state of mind and potential for action of Indian subjects in a post-EIC world. The lunacy acts were not at odds with the new government, however. The impetus behind a new network of lunatic asylums could be seen as complementing the goals of the British Raj: this was a government eager to distance itself from the previous administration, but also eager to prevent further economic and military losses, and to consolidate its control over its colonial subjects through the establishment of new institutions. This was a moment where the British government provided a different mode of sovereignty and an altered lens of authority, and Indian communities were also encouraged to engage with their new rulers in a different light.

In this chapter, I will show how the process of colonial assimilation and reform engendered a particular view of the Indian mind, and permitted the creation a new colonial institution. I will argue that the lunacy acts were a direct consequence of asylum reform occurring in Britain at this time. There had already been some reimagination of the Indian public in education and politics earlier in the century, through the participation of Indian elites in intellectual debate with Europeans.⁵⁷ Despite a brief period of hostility towards the leaders of the 1857 rebellions, the British governing bodies maintained a sense of duty towards the Indian people, as evidenced by the social reform policies of the British Utilitarians.⁵⁸ The creation of native lunatic asylums showed a concern with those

⁵⁷ Chris A. Bayly, *Rulers, Townsmen and Bazaars: North Indian society in the age of British expansion, 1770-1870* (Cambridge: Cambridge University Press, 1983), 263-302.

⁵⁸ Thomas Metcalf, *The Aftermath of Revolt*, 3-43.

Indians who were not already part of elite intellectual debate. Adopting the English lunacy laws into British Indian legislation can be considered a strategic move by the new government to include a larger proportion of the Indian populace within their purview, while simultaneously performing a charitable service for their new subjects.

Certainly, the events of 1857-58 flavoured the environment in which these new native asylums were built. However, asylum reform in England and a variety social and political negotiations under the EIC *before* 1857 had already established a need for native lunatic asylums. By examining the ideologies and infrastructure already in place before 1857, I will demonstrate that there were a whole host of reasons for the British to establish asylums in India. By examining the lunacy laws in Britain, and their relationship to the Victorian Poor Laws, I will show how the Indian lunacy laws were not a move for social control by the new British Indian government; rather they belonged to the legacy of a social welfare system, which can be extended as far back as Mughal rule in the pre-colonial period, that was already implicit in the Indian subcontinent. I will show how the new science of phrenology, and the impetus for English education coupled with these preexisting systems of care to create possibilities for a new kind of colonial institution in which a new vision of the Indian subject could be constructed. Education through universities and schools worked in parallel with the care and treatment in the asylums – I argue that the ‘unhealthy’ native mind had to be understood within the government’s larger concerns to consolidate a medical or scientific framework of native care.

The next section details some of the theoretical ideas that made the establishment of government legislation for native insanes seem reasonable and necessary.

Expectation and Care: Pre-existing Indian systems

Contrary to what we might expect, the publication of these lunacy laws and the building of lunatic asylums by the British Government was not met with local resistance. To a varying degree, the Indian public quickly embraced the new institution. What explains their acceptance? There were both pragmatic and theoretical reasons for the adoption of the British lunatic asylum. Playing on the historiographical ideas of continuity and rupture, this section will outline the historical precedence that encouraged the Indian public to accept the new governmental system for native insanity.

Practicably, prior to European colonization, Mughal rule of India had already established a system of care for the vulnerable. Antecedents for the care of the insane under the Mughals included familial support and the *bimaristan*.⁵⁹ *Bimaristan* is the Persian word for ‘hospital’ in the medieval Islamic world, deriving from *bimar* (the Persian word for ‘patient’) and *bimaree* (meaning ‘disease’).⁶⁰ Dominik Wujastyk has revealed how Mughal physicians were among the earliest to distinguish between institutions that sought to cure insanity, rather than simply confine and isolate the mad.⁶¹ It is remarkable that special provision for the insane in Islamic hospitals occurred as early

⁵⁹ Sharif Kaf Al-Ghazal, *The Origin of Bimaristans (Hospitals) in Islamic Medical History* (Manchester: Foundation for Science, Technology and Civilization, 2007).

⁶⁰ J.K. Anand, “Etymology of the word ‘Bimaristan’,” *Journal of the Royal Society of Medicine* 100, 2 (2007): 69.

⁶¹ The long history of medicine in India, and the regrettable lacuna on South Asian hospitals in medical historiography, is addressed in Dominik Wujastyk, “The Nurses Should Be Able to Sing and Play Instruments: The Evidence for Early Hospitals in South Asia,” accessed on July 12, 2013. <http://univie.academia.edu/DominikWujastyk/Talks>.

as the ninth century.⁶² As well as fixed locations for the cure of the sick and the insane, the Islamic Empire also established “mobile” *bimaristans*, traveling clinics with doctors and pharmacists, funded by the state and permitting state care to reach the disabled, the disadvantaged and those in remote areas, even those in prisons.⁶³ Caring for and attempting to cure the socially deviant, the vulnerable, or the insane, in whatever way they were defined, was a foundational element of Mughal India, with its strong ties to the Islamic Empire before territorial acquisition by the British. In this way there was some continuity between the mid-nineteenth century British endeavours, and systems of care by their colonial precedents. However, it is likely that the British asylum system was the first widespread institutional form of psychiatry available to Indians across the subcontinent, and in this respect the 1858 lunacy laws did produce a new Indian institution.

The public imagination was already predisposed towards trusting the ‘powers that be’ to care for the most vulnerable elements of the population through *bimaristans* and early welfare systems. There were also elite Indian ideologies to support the notion of care by one’s rulers. The *Arthashastra* was a Sanskrit text, a couple of millennia old, which described the idealized foundations of efficient and ethical statecraft. Even though few nineteenth-century Indian men and women had read this text, it continued to provide an archetype of political thought that defined Hindu political theory, much like Plato’s

⁶² A *bimaristan* was founded by Ibn Tûlûn in Egypt in AD 872-73, and it appears to have provided for the insane. Michael W. Dols, “Insanity and its treatment in Islamic Society,” *Medical History* 31 (1987): 3.

⁶³ There is a great deal of evidence for these medical institutions in near- and middle-eastern countries. I.B. Syed, “Islamic Medicine: 1000 years ahead of its times,” *Journal for the International Society for the History of Islamic Medicine* 2 (2002): 2-9; C. Stone and P. Lunde, “Early Islamic hospitals: in the hospital bazaar,” *Health Soc. Serv. Journal* 91 (December 1981): 1548-1551; Andrew C. Miller, “Jundi-Shapur, *bimaristans*, and the rise of academic medical centres,” *Journal of the Royal Society of Medicine* 99, 1 (December 2006): 615-617.

Republic had done in Europe. The *Arthashastra* contained several detailed sections on social welfare, as well as the need for effective public administration and economic prosperity. Public administration, economic prosperity, social welfare, diplomacy and military readiness were considered the five essential elements of a successful state.⁶⁴ Social welfare was defined as “the increase in economic activity, the protection of livelihood, the protection of weaker sections of society, consumer protection, the prevention of the harassment of citizens, and the welfare of prisoners and labour.”⁶⁵ The weaker sections of society were “Brahmins, ascetics, the minors, the aged, the sick, the debilitated, those in a drunken state, the insane, those suffering from hunger, thirst or fatigue, those who had eaten too much, the handicapped, the helpless, and women,” and the governing sovereign and his judges had to provide “special consideration” towards them.⁶⁶ When legislation for the care and treatment of ‘native insanes’ was enacted in 1858, the *Arthashastra*’s legacy in public imagination gives us some idea as to why these seemingly alien laws were easily accommodated by Indian communities.

Layered on top of the legacy of the *Arthashastra*, Hindu law itself acknowledged and made provisions for insanity. Under the EIC, the British had had a tradition of borrowing existing customary laws in India to inform and facilitate the administration of their own laws. The *Mitakshara* and *Dayabhaga* were both systems of Hindu law, and were first translated into English for official legislative use by 1810, and used as a direct

⁶⁴ Subhash C. Kashyap, *Concept of Good Governance and Kautilya’s Arthashastra* (New Delhi: Indian Council of Social Science Research, 2003), 17.

⁶⁵ L. N. Rangarajan, *Kautilya. The Arthashastra* (New Delhi: Penguin Books India, 1992), 91.

⁶⁶ *Ibid.*, 92.

authority for governing the Indian public by the new Crown in 1858.⁶⁷ Under *Mitakshara*, insanity was a bar to inheritance; once an individual had been established as insane, he or she was no longer entitled to a share of his or her father's estate. Moreover, the heir of a lunatic was, under the same law, automatically granted ownership of the lunatic's estate.⁶⁸ Rachel Sturman has recently argued against the idea that Hindu Law in colonial India drew on conservative traditions, borrowing from liberalism and other modern legislative frameworks;⁶⁹ a simple comparison of the language in the *Mitakshara* and Act 35 of 1858 shows that indeed the latter borrowed directly from the former. Even the new British government explicitly stated that in cases where its instructions seem contradictory to the *Mitakshara*, "Act XXXV of 1858 does not affect the general provisions of Hindu law".⁷⁰ Such a conscious effort for legislative continuity by the Government of India meant local communities were not conflicted at the imposition of the lunacy laws, either as recipients of asylum care or – as the next chapter will show – as working attendants and assistants in these institutions.

Systems and structures of care also existed from the time of Company rule in India. The British had established lunatic asylums in South Asia from the late eighteenth century onwards, and there is some argument to be made that the Portuguese had made

⁶⁷ Robert Lingat, *The Classical Law of India* (Berkeley: University of California Press, 1973), 113. Hindu Law (the *Mitakshara* and the *Dayabhaga*) continued to influence Indian legislative matters even after Indian independence in the twentieth century: Justice Markandey Katju, "The Importance of *Mitakshara* in the 21st Century", *Supreme Court Cases* 7, 3 (2005): 1-7.

⁶⁸ Robert Bryson, *The Indian Lunacy Manual: Being A Summary of the Lunacy Acts and Rules regulating the admission into, detention in, and discharge from Government Lunatic Asylums of Private and Public Patients* (Calcutta: R. Vivekananda Press and Riggindotham & Co., 1910), 9.

⁶⁹ Rachel Sturman, *The Government of Social Life in Colonial India: Liberalism, Religious Law, and Women's Rights* (Cambridge: Cambridge University Press, 2012), 70-107.

⁷⁰ Lunatics Act of 1858 (34 & 35 Vict., c. 22).

arrangements for the treatment of the insane even earlier than that.⁷¹ These European asylums were initially privately run and dedicated to the treatment of white travelers, officers and merchants whose constitutions had failed “in the heat”. As the East India Company became increasingly a military and administrative colonial power, it also became concerned with the mental health of its employees.⁷² In 1795, the Commander-in-Chief of the Bengal Army wrote to the Governor-General to propose a temporary “house” at Monghyr,⁷³ for three EIC sepoys who had gone insane and were simply locked in a room within the Commander’s garrison. The Governor-General sanctioned a facility for up to twenty patients, “which could be expanded further should there be the demand.”⁷⁴ The early nineteenth-century European asylums thus provided a precedent to the care of insanes in India, prior to legislation for natives. These asylums were located in urban centres, in cantonments, wherever there was a high density of Company employees.

Bhowanipore Asylum was another of these European asylums, built in the heart of Calcutta, to house and treat officers whose behaviours became erratic on employment in the EIC. Officers were only temporarily detained at Bhowanipore, before travelling to

⁷¹ For a detailed account of the British “European-only” asylums, see Waltraud Ernst, “Asylums in Alien Places,” in *Anatomy of Madness: Essays in the History of Psychiatry*, eds. W. Bynum et al. (London: Tavistock, 1988), 48-70.

⁷² Hill stations were also established in the early nineteenth century to alleviate the stresses of working as an EIC officer in an alien country and climate. These were usually located, as their names suggest, in the hills and mountains of the Indian subcontinent, where the temperature was cooler and the air less humid, e.g. Srinagar in Kashmir, and Nilgiri in Madras. For more on the believed constitutional benefits of these hill stations, see Judith T. Kenny, “Climate, Race and Imperial Authority: The Symbolic Landscape of the British Hill Station in India,” *Annals of the Association of American Geographers* 85 (4): 694-714; and also Dane Keith Kennedy, *The Magic Mountains: Hill Stations and the British Raj* (Berkeley: University of California Press, 1996), 19-38.

⁷³ Present-day Munger, in the Indian state of Bihar.

⁷⁴ Letters received from Bengal, 14 May 1795, section 27, BL V/18/4301.

the hill stations (if their symptoms were deemed curable) or to the port city of Bombay to the west, and thence to Britain.⁷⁵ For example, in 1844 a Lieutenant in the Company's Indian Navy produced symptoms of walking "the deck night and day successively" and behaving "in the most extravagant manner" at what he believed to be his own hanging. Despite exhibiting strange behaviour for almost five years, it was only after "his Conduct had attracted the notice of every one on board", including 'native' employees, that this Lieutenant was admitted to an EIC asylum in Colaba.⁷⁶ EIC treatment of European insanity was a strategic rather than charitable affair: it was embarrassing for the rest of the EIC if officers exhibited their symptoms too publicly, and it was believed to jeopardize their authority over the less civilized Indians. Waltraud Ernst has written at length about these earlier European-only lunatic asylums. She examines the ideological and bureaucratic influences on policies towards the European insane from the end of the eighteenth century until the middle of the nineteenth century. In her narrative, European asylums had an entirely different character from domestic models for institutional care in Europe.⁷⁷

Thus Indian subjects already had certain beliefs about the nature of colonial rule and had certain expectations of their British rulers throughout the nineteenth century.

⁷⁵ Pembroke House in Ealing, west London, was reputed with receiving many of these distressed or disgruntled EIC employees. The high cost of maintenance in a English asylum was prohibitive in comparison to the European asylums in India, thus EIC employees were often repatriated within a year and returned to India. An older argument about the lack of treatment options in India is put forward in William F. Bynum, "Patients and their treatments," *Current Opinion in Psychiatry* 4, 5 (October 1991): 730-733. Waltraud Ernst has since written about the economic competition for these disgruntled EIC employees in "Asylum Provision and the East India Company in the Nineteenth Century," *Medical History* 42 (October 1998): 476-502.

⁷⁶ Colaba Fort was a military fortification just south of Bombay, on India's west coast. From here it was easy to transport EIC employees back to England, on any outbound vessel. Ernst, "Asylum Provision," 478.

⁷⁷ Strangely, Ernst says very little about the relationship between European and Indian asylums, despite the wealth of research she has done to date. Ernst, *Mad Tales from the Raj*, 14-15.

This would have flavoured the milieu into which the new Government of India established native lunatic asylums. The next section details the ways in which pre-existing ideas from Europe translated to India, and influenced the EIC and Crown in their concerns for native insanity.

Nineteenth-century science and medicine: British expectations and ideology

The overarching view of these “less civilized Indians” was variable. Unlike European conquests in Africa in the twentieth century, European interaction with local Indians in the nineteenth century was lengthy and nuanced. The Colaba Lieutenant may have seemed a public embarrassment for his regiment, but other British officers felt warmly, even compassionate towards the natives. In reviewing the state of European asylums in the subcontinent for the *Calcutta Review* in 1856, one British officer acknowledged the perseverance of these pre-existing ideologies:

Cruel as the natives of India naturally are both to man and to beast, cruelty to lunatics is not one of their characteristics [...]; we shall propose to use the feeling of compassion which already possesses them in a plan to offer for the future advantage of Hindustan.⁷⁸

The date of this quote is key: this was a conversation proposing lunacy legislation before the disbanding of the EIC and the establishment of Crown rule of India. EIC officers were eager to expand the system for European lunacy to native lunacy even without extraneous knowledge about pre-existing welfare systems in India. Local men and women had already seen European asylums in India, even if the erratic behaviours of EIC employees were hidden from them as much as possible. The asylum would have thus been a familiar, and not alien, institution in India. James Mills has argued for the

⁷⁸ T. Hastings, “Lunatic Asylums in Bengal”, *Calcutta Review* 26, 52 (1856): 592.

continuity of modern psychiatric services across Indian Independence in 1947; I would extend Mills' argument to this earlier period, and suggest there was continuity in expectations of care for insanes from the early nineteenth century.⁷⁹ This is not a teleological argument for a long history of modern psychiatry; the British-built native asylum was still novel compared to its predecessors, but the sentiments underlining the care of lunatics went beyond the conscious attempt for consolidation and control by the new British Government.

Indian expectations towards their colonial rulers were not the only ideologies to influence the brand of asylum care that would be enforced by the 1858 Lunacy Acts. British scientific enterprise flourished in the nineteenth century and, coupled with surveys and expeditions into the uncharted or uncolonized parts of the world, strongly affected the way they viewed or documented the Other.

Indra Sengupta and Daud Ali have spoken to this idea in a recent edited volume: "[N]o single theory of colonial knowledge is possible... knowledge had diverse uses and receptions in India's colonial past, as it continues to have in the present."⁸⁰ The 1857-8 uprisings had made it clear to the British that their subjects could organize and react in stark opposition of British colonial paradigms. The new government of India underwent certain practical transformations in order to rule its most prized colony more effectively, but it also moved to embody a different governing mentality. After almost a hundred years of trading with and ruling the native Indian body, there was a new priority to

⁷⁹ James Mills, "The History of Modern Psychiatry in India, 1858-1947," *History of Psychiatry* 12, 48 (December 2001): 431-458.

⁸⁰ Indra Sengupta and Daud Ali, "Introduction," in *Knowledge production, Pedagogy and Institutions in Colonial India*, eds. *idem*. (New York: Palgrave Macmillan, 2011), 1.

understand the native mind. For a century, the EIC had relied upon the building of native hospitals, prisons, barracks and universities, to know the bodies of its Indian subjects, but the care and cure of the insane had remained unacknowledged, or unimportant, all of this time.

With the reforms in place in Britain, and a rejection of the governance that led to native rebellion, the governing body of India – the Crown – was faced with the need to understand the native mind. What was this native mind? Two major ways of thinking contributed to the Crown’s governing ideals in India: one was to develop better knowledge of the Other (via the new science of phrenology, for example, and a growing body of social theory); the second mode of thinking came out of the English education reforms.

In mid-nineteenth-century British India, there was a complex correlation between colonial knowledge and the science of phrenology. Theories about race were essential to the application of phrenology, especially in the subcontinent, which possessed so many potential specimens with which to prove phrenological theory. Scientific examination of the Indian skull (in all its colonial variations) represented a way to transition from knowing the Indian body to knowing the Indian mind, and evidence uncovered from these examinations legitimized British colonial policies.⁸¹ In turn, the punitive machinery of the colonial state, the colonial prisons and the judicial system, borrowed heavily from

⁸¹ See Andrew Bank, “Of ‘Native Skull’ and ‘Noble Caucasians’: Phrenology in Colonial South Africa,” *Journal of South African Studies* 22 (3): 387-403; Paul Turnbull, “‘Rare work amongst the professors’: the capture of indigenous skulls within phrenological knowledge in early colonial Australia,” in *Body Trade: Captivity, Cannibalism and Colonialism in the Pacific*, ed. Barbara Creed and Jeanette Han (New York: Psychology Press, 2001), 3-23.

phrenologists to produce and confine many Indians as criminals.⁸² Most famously, the science of phrenology permitted the state to create a whole caste of Indians *de novo*, a caste of hereditary thugs, born criminals, genetically predisposed to cause trouble or the British government. The wealth of EIC records on this topic far exceeds the scope of this chapter,⁸³ but it is sufficient to argue at this point that there was a continuity between the phrenological leanings of the EIC to group Indians by caste and crime, and the desire to know the Indian mind with new imperial legislation in 1858.

The process of documenting the Other, as scientifically legitimate criminals or inferior minds, was not a hegemonic project.⁸⁴ The judicial branch of the government put forward its own categories with which to know and confine its subjects after 1858, but there was also a great deal of ethnographic data informing the colonial mentality of India's new imperial government. Much of the ethnographies of the Indian populace were born, hand in hand, with the development of evolutionary social theory, or "colonial sociology". Bernard Cohn describes this as a structure of knowledge about India, shaped by new social sciences, which in turn shaped the structure of British political control.⁸⁵ Coupled with a growing population of ethnographic researchers (the precursors to modern anthropological scientists), India appeared as a multitude of local communities

⁸² Wagner, "Confessions of a Skull," 2. Wagner's micro-historical approach, in which specific case studies can be applied to larger issues regarding colonial knowledge, is one approach I use to underpin my own work.

⁸³ For further information on the knowledge produced from criminally-labelled Indian bodies, see Andrew Major, "State and Criminal Tribes in Colonial Punjab: Surveillance, Control and Reclamation of the 'Dangerous Classes'," *Modern Asian Studies* 33, 3 (1999): 657-688.

⁸⁴ Wagner, "Confessions of a Skull," 2-3.

⁸⁵ Bernard Cohn, *An Anthropologist among the Historians and Other Essays* (Delhi: Oxford University Press, 1987), 11.

held rigorously within caste, tribe, linguistic and religious structures. The British layered this seemingly rigorous network with their own intellectual and administrative lenses, using census surveys and reams of bureaucratic paperwork to reinforce and reify a set of cultural assumptions about Indian ways of living that would echo long after the nineteenth century. Clive Dewey has described this presentation of assumption and stereotype within highly structured scientific and bureaucratic processes as a “dazzling vision of the science of government”, which reached its brightest pinnacle at the end of the nineteenth century.⁸⁶ The theoretical underpinnings of this “dazzling vision” are the focus of the following paragraphs.

Social theory presented some classical ideas about humanity developing along a fixed path, with modern European ways of thinking as the pinnacle of that development. Nicholas Dirks has spoken to this idea, arguing that:

Colonial conquest was not just the result of the power of superior arms, military organization, political power, or economic wealth [...]. Colonialism was made possible [...] by cultural technologies of rule [...]. Colonial knowledge both enabled conquest and was produced by it; in certain important ways, knowledge was what colonialism was all about.⁸⁷

Many of the officers who came to British India after 1857 would have been familiar with the evolutionary social theory that justified Europe’s conquest of the rest of the world. It was no longer just an issue of physically controlling the colony, but mastering vernacular languages, representing India through cartographic technologies and exhibiting the

⁸⁶ Clive Dewey, *The Settlement Literature of the Greater Punjab* (Delhi: Manohar, 1991), 28.

⁸⁷ Nicholas Dirks, *Castes of Mind: Colonialism and the Making of Modern India* (Princeton: Princeton University Press, 2001), 245.

subcontinent's archaeology. By delineating India's natural environment, and creating a medium through which to understand the Indian mind, the British were able to flaunt their position at the pinnacle of civilization and govern India more effectively.

Cousins Charles Darwin and Francis Galton had already enjoyed some popularity with the intellectual elites of Britain prior to 1858, but their theories became especially pertinent with the colonial reorganization inherent to the Government of India Act. Charles Darwin is, of course, credited with championing a scientific theory of evolution in *On the Origin of Species*, but Francis Galton melded these ideas with race, class, and type, especially beyond upper-middle class England. Galton's argument for there being a strong connection between fingerprints and race became a useful application for the British Raj, which struggled to distinguish between so many brown subjects, especially when moving indentured labourers or Indian soldiers.⁸⁸ Galton also wrote a commentary about the Indian psyche being naturally predisposed to lie (which is why fingerprinting was a scientific method designed to distinguish and capture the Indian perpetrator): "the features of the natives are distinguished with difficulty... there are strong motives for prevarication, especially connected with land-tenure and pensions, and a proverbial prevalence of unvaracity."⁸⁹ As in phrenology, the psyche was inherently related to race, and this permitted an institution that would accommodate colonial subjects on the basis of race and behaviour. Colonial governance of India was rooted in these kinds of social,

⁸⁸ Galton's friend and colleague, William Herschel wrote to *Nature* magazine to refute Galton's claims that fingerprinting was a reliable method for identifying race. W. J. Herschel, "Skin Furrows of the Hand," *Nature* 23, 578 (November 1880), 76.

⁸⁹ Francis Galton, *Finger Prints* (London; New York: Macmillan & Co., 1892), 14.

cultural and racial theories: it was necessary to build a model of the Indian mind somehow to understand the Britain's imperial subjects.

Colonial institutions were ideal spaces to study and reform Indian minds. As Carla Yanni has argued, universities and asylums represent two parallel efforts to affect the mind: the university educates the 'healthy mind', where the asylum hopes to reeducate 'unhealthy minds'.⁹⁰ Due to prevailing racial ideas about Indians as Other, however, the British Government could not easily distinguish between health and unhealthy minds in the colony. English education was one of the key social reforms in colonial India before Crown rule, and continued to have a significant influence on colonial thought afterwards. Schools were one of the spaces in which the Indian psyche could be known and assisted. Starting in 1835, with the publication of Thomas Babington Macaulay's infamous "Minute on Education", many British intellectuals were moved to dismiss local, or "oriental", knowledge and embrace a Western model of education to reform their colonial subjects.⁹¹ At the intersection of European learning and colonial power, Macaulay imagined millions of Indians in "a class of persons Indian in blood and colour, but English in tastes, in opinions, in morals and in intellect" who would mimic their British rulers and propagate British rule.⁹² Within the ideology of Anglicized colonial education, a key feature was the use of English, rather than Indian vernacular, language. Colonial Anglicists believed that speaking English would automatically aid

⁹⁰ Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007), 8.

⁹¹ Thomas Babington Macaulay, "Minute by the Hon'ble T. B. Macaulay, dated the 2nd February 1835," in *Bureau of Education. Selections from Educational Records, Part I (1781-1839)*, ed. H. Sharp (Calcutta: Superintendent, Government Printing, 1920; rpt. Delhi: National Archives of India, 1965), 107-117.

⁹² Homi Bhaba calls this "flawed colonial mimesis" in "Of Mimicry and Man: The Ambivalence of Colonial Discourse", *October* 28 (Spring 1984): 128.

Indians' internalization of British colonial policies; to speak English was to be English.⁹³ Macaulay's vision was initially imposed in the building of thousand of primary and secondary education institutions. Just before the EIC was officially disbanded, universities were established in Calcutta, Bombay and Madras, to further this idea. By 1887, more than half of the British Raj's civil service appointments were held by native men. An educated professional state bureaucracy was key to promoting British ideals, and universities were fundamental to their existence.

The notion of social reform is key to understanding the environment that produced native lunacy legislation. The Government lacked the bureaucratic tools to effect change, without military intervention, in a colony that was many times larger than the British Isles. Social reform was necessary to make Indian subjects complicit in British governance of India. Chris Bayly has argued that successful intelligence-gathering through local networks of knowledge was a critical feature of the British domination of India. In fact, he suggests that failure to adequately utilize these networks contributed to the course of the uprisings in 1857 and 1858.⁹⁴

One way to achieve reform in a hastily established sovereignty like British India was to borrow from existing British legislation, despite the fact that British India was quite unlike Britain. The Government of India was not alone in this endeavour: the Indian Lunacy Act, the Lunacy (Scotland) Act and the Canadian Provincial Asylum Acts all occurred within fifteen years of the English Lunacy Act, and all borrowed heavily

⁹³ This argument is taken even further by Tejaswini Niranjana, "Translation, Colonialism and the Rise of English", *Economic and Political Weekly* 25, 15 (April 1990): 773-779. Once "truly Anglicized", the goal was for Indians to seek out their own historical 'truths' by reexamining and translating Indian texts into English.

⁹⁴ Chris A. Bayly, *Empire and Information: Intelligence Gathering and Social Communication in India, 1780-1870* (New York: Cambridge University Press, 2000), 2-9.

from this pre-existing legislation. We can reframe this better if we look at Chris Hamlin's monograph on social reform in England. He writes: "In the name of efficiency and science... Chadwick was able to equate in the public mind sanitation and sanitary works with the attainment of political stability and social justice."⁹⁵ The mid-nineteenth century legacy of Edwin Chadwick was his Poor Law, where he argued that filth, not poverty, was the cause of moral decline, fever and death. By combining the moral economy of medicine with the political economy of an expanding industrial capitalist empire, Chadwick was able, under the tutelage of Jeremy Bentham, to achieve some of the most far-reaching legislative reform in this period. It is this vision to which the new Government of India was attracted: a vision that directed their own desire for reform in India, and a vision that shaped the legislation they borrowed. Rather than assuming that the 1858 Lunacy Acts, were a direct consequence of the events of 1857-1858, I want to show how a seemingly charitable network of asylums were established by a Government looking for "political stability and social justice" in a colonial setting.

In the Indian context it would be simple to assume the new Government wanted to besmirch the leaders of the Rebellion, punishing them with commitment to a psychiatric institution, rather than a prison, where pathology and stigma would prevent their becoming martyrs for a new wave of uprisings.⁹⁶ Aside from the short period of time between quashing the rebellions and passing the lunacy acts, there is no positive evidence in the historical record to show that the latter were a direct result of the former. The

⁹⁵ Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick, Britain 1800-1854* (Cambridge: Cambridge University Press, 1998), 245-274.

⁹⁶ David Arnold, *Police, Power and Colonial Rule: Madras, 1859-1947* (Delhi; New York: Oxford University Press, 1986), 7-35.

legislative discussions preceding the drafting of these lunacy acts do not mention a “mutiny” or a need to prevent further uprisings. Moreover, the natives populating the asylums were not associated with the Rebellion. With a dearth of demographic and legislative materials to support such a causal relationship, we cannot argue that the 1857-8 uprisings created a need for native lunatic asylums.⁹⁷ We may nuance our argument to suggest that the Lunacy Acts held some sentiments of reconciliation with the Indian people, after a tumultuous mid-century war. However, to argue that the native asylum was a colonial tool for managing the rebellious elements of 1857 and 1858 would be to make an argument that the archives do not support.

The 1857-8 Uprising: Not a reason for Native Asylums

To eat pigs and drink wine, to bite greased cartridges, and to mix pig’s fat with flour and sweetmeats, to destroy Hindu and Mussulman temples on the pretence of making roads, to build churches, to send clergymen into the streets and alleys to preach the Christian religion, to institute English schools and pay people a monthly stipend for learning the English Sciences, while the places of worship of Hindu and Mussulman are to this day neglected – with all this house can the people believe that religion will not be interfered with? ...Let not our subjects be deceived.⁹⁸

So proclaimed the Begum Hazrat Mahal of Oudh in the aftermath of the 1857-8 rebellion, in response to Queen Victoria’s statement that the British did not intend to convert all Indians into Christians. In the following years, the new Government of India made every attempt to make reconciliation with the Indian elites and “disclaim alike the right and the

⁹⁷ The fact that the law, and not the new government’s Medical Department, oversaw and managed most of the lunacy legislation is important: as will be explored in chapter 4, there was an administrative oversight between the Judicial and Medical Branches of British India as they negotiated control over these new colonial spaces. As will be shown in the next chapter, this permitted a variety of actors to permeate these spaces and enact their own practices, thus constructing a system of care that borrowed from local and British ideas of asylum management.

⁹⁸ Quoted in Arunabha Ghosh, “Women in Indian Politics,” *Rabindra Bharati Journal of Political Science* 6 (2004): 46.

desire to impose our convictions on any other subjects.”⁹⁹ The Begum’s proclamation was sent from Nepal, to which she had escaped during the uprisings, in lieu of accepting the Empire’s offer of a pardon and a pension to aid civil reconstruction. Like many labouring and elite Indians, the Begum was untrusting of the new imperial government, which in many ways was contiguous with the old EIC government. Within this context of mistrust and miscommunication, the new Government of India made many concessions in an attempt to reconcile with its Indian subjects.

Changing priorities and increased complacency meant that subsequent reforms could only occur from the top down, without much regard for or alliances with the majority of the Indian people. Lord Dalhousie, who had officially established¹⁰⁰ the “doctrine of lapse”, spent a great deal of EIC money spurring on the modernization of India through bureaucratic, civil service and religious reforms.¹⁰¹ His policy was to Europeanize the country and consolidate British authority.¹⁰² He set up a Public Works department, to build and upgrade telegraph poles, railway lines and port towns. A uniform postal service, across all three Presidency towns, enforced the existing transport links and allowed for even faster official communications, newspapers and letters to be

⁹⁹ Quoted in Sidney Lee, *Queen Victoria: a Biography* (London: Smith, Elder & co., 1902), 288-290.

¹⁰⁰ There is some debate as to whether the doctrine of lapse was used to annex the state of Kittur in 1824, before such a measure was made into official policy by Dalhousie.

¹⁰¹ Suresh C. Ghosh, “The Utilitarianism of Dalhousie and the Material Improvement of India.” *Modern Asian Studies* 12, 1 (1978): 97-110. Dalhousie’s Reforms included the telegraph, the railway, irrigation systems, the doctrine of lapse and the postal system; see Barbara D. Metcalf and Thomas R. Metcalf, “Dalhousie: The Unification of Sovereignty and Networks of Communication,” *A Concise History of Modern India* (Cambridge: Cambridge University Press, 2006), 94-99.

¹⁰² Lawrence James, *Raj: The Making and Unmaking of British India* (New York: St. Martin’s Press, 1997), 116.

sent.¹⁰³ Despite the cost of war in the Punjab and in Burma, Dalhousie directed funds towards the construction of a massive Ganges canal, to irrigate large swathes of central India and stabilize the agricultural industry.¹⁰⁴ Within the civil service, promotions were given based on merit rather than seniority, and Dalhousie forbade any of these officers from participating in trade.¹⁰⁵ Dalhousie was also instrumental in establishing new engineering colleges, and encouraged Christian missionaries to provide care for needy or low-caste Indians.¹⁰⁶ The Caste Disabilities Act of 1850 permitted Indian converts to Christianity to inherit property, and implied to the Indian public that Dalhousie's reforms were as much a concerted Christian conspiracy to shake the foundations of India's religious orthodoxy as they were about the improvement of the country.¹⁰⁷ There were many more reforms, too, all of which were intended to improve the long-term efficiency and colonial stability of the country; in the short-term, however, the cost of reform put an inordinate amount of strain on the EIC taxation system, and overextended the colony's resources.

¹⁰³ India's first Post Office Act had been established in 1837, but the addition of telegraph lines under Dalhousie lent a real impetus to creating a pan-India postal system.

¹⁰⁴ Indians living alongside the canal benefited greatly from the canal's construction, but the increased soil salinity also negatively affected thousands of acres of farmland. David Gilmour, *The Ruling Caste: Imperial Lives in the Victorian Raj* (New York: Farrar, Straus and Giroux, 2005), 9.

¹⁰⁵ Lionel J. Trotter, *Life of the Marquis of Dalhousie* (London: W. H. Allen, 1889), 233.

¹⁰⁶ I see some continuity with the post-EIC lunatic asylums in Dalhousie's institutional reforms of the mid-nineteenth century. I do not believe Dalhousie meant that Christian missionaries should care for the insane, but I think it timely that his reform was articulated very soon after the 1845 Lunacy Acts/Poor Law in Britain, of which Dalhousie would have been well informed.

¹⁰⁷ Act XXI of 1850 abolished all laws affecting the rights of persons converting to another religion or caste. Government of India, *The unrepealed general acts of the Governor General in Council [...] from 1834-1903* (Calcutta: Office of the Superintendent of Government Printing, 1893), 72-73.

Dalhousie's zeal for an accelerated pace of reform in India represented the zenith of what had been a hive of activity in the preceding decade in the subcontinent. The EIC armies were occupied with the Anglo-Sikh Wars in 1848-9, resulting in the annexation of Punjab and Sindh, and a variety of battles in Burma and at the imperial frontiers. The loss of manpower during the Santal Expedition was the first of many advertisements to the world that British resources were not as powerful or efficient as they believed: even poorly equipped peasant armies were able to cause huge logistical problems for the EIC army. Tired and thinly distributed across the subcontinent, Indian soldiers were stationed in the newly annexed states, a prudent move to secure and control new territories, which left great swathes of the Northern and Central states without a standing army.¹⁰⁸ This simultaneous reform in situ and overextension of resources abroad meant there was a disgruntled population at home in India, and an administrative infrastructure lacking in military enforcement at large.

To recover, the British Government had to spend 30,000,000 GBP simply to reconstruct the colony. These figures were sufficient to convince London politicians that the EIC could no longer maintain sole responsibility for such a valuable imperial commodity; henceforth, the British Crown would assume its full charge. Moreover, the proportion of native troops would never again be allowed to exceed two-to-one over British troops, and artillery would be exclusively in the hands of the British regiments. In

¹⁰⁸ Hermann Kulke and Dietmar Rothermund, *A History of India* (London; New York: Routledge, 2010), 230-232.

the Bengal Army, the number of native regiments was reduced from 146 before the 1857, to 72 after 1858, and similar reductions occurred in the Bombay and Madras armies.¹⁰⁹

Dalhousie's Reforms had had positive and negative effects on the colony. The stage was set for further reform: removing some of the more extreme Company measures, and providing new services for the newly-colonized country. Some EIC initiatives were continued into Crown rule of India. For example, the education reforms that had begun in the 1830s continued to be implemented: learning English was to be encouraged, not only as an encouragement of the adoption of British norms, but as a policy that had already garnered Indian support.¹¹⁰ Public health reforms and communications technologies (such as the railway and the telegraph) also continued to expand.

Were the lunacy acts part of a singular move for reform in a new British India? While Dalhousie's Reforms provided continuous impetus for greater consolidation and reform under the new Government, the influence of phrenology, evolutionary social theory and pre-existing systems of welfare show how the British vision of India was never informed by a single coherent set of ideas.¹¹¹ This was a moment of change at many different levels of British Indian life: social, political and cultural reforms were occurring simultaneously. One of the biggest changes was the physical ratio of British to Indian subjects. Before 1857, two hundred million Indians had been ruled by just 40,000

¹⁰⁹ Peace was not officially declared until July 9, 1859, when Lord Canning proclaimed: "War is at an end. Rebellion is put down. The Noise of Arms is no longer heard where the enemies of the State have persisted in their last Struggle; the Presence of large Forces in the Field has ceased to be necessary. Order is re-established, and peaceful Pursuits have everywhere been resumed." Quoted in C. E. Buckland, *Bengal Under the Lieutenant-Governors: Being a Narrative of the Principal Events and Public Measures During Their Periods of Office, from 1854 to 1898* (Bengal: S. K. Lahiri & Company, 1901), 170-174.

¹¹⁰ Metcalf, *Aftermath of Revolt*, 60.

¹¹¹ *Idem.*, *Ideologies of the Raj* (Cambridge: Cambridge University Press, 1995), 28-35.

British troops with 232,000 Sepoys under their command. By 1861, there were just 135,000 native troops to 70,000 British men. The differences between Indian and British were significant enough to garner bringing thirty thousand extra British men. The table below shows how the military ratio was echoed amongst the medical staff within ten years.

Table 1: Accounts and Papers of the House of Commons, 1871.

72

CORRESPONDENCE RELATING TO

COMPARATIVE STATEMENT of the MEDICAL ADMINISTRATIVE STAFF of the
Three Presidencies' British and Indian Services, in 1861 and 1869.

BENGAL.			
1861.		1869.	
BRITISH SERVICE.		BRITISH SERVICE.	
Inspector General of Hospitals - - -	1	Inspector General of Hospitals - - -	1
Deputy Inspectors General of Hospitals - -	2	Deputy Inspectors General of Hospitals - -	6
		Staff Surgeons Major in charge of Circles - -	2
TOTAL - - -	3	TOTAL - - -	9
INDIAN SERVICE.		INDIAN SERVICE.	
Principal Inspector General - - - -	1	Inspector General of Hospitals - - -	1
Inspectors General - - - -	2	Deputy Inspectors General of Hospitals - -	11
Deputy Inspectors General of Hospitals - -	12		
TOTAL - - -	15	TOTAL - - -	12
MADRAS.			
BRITISH SERVICE.		BRITISH SERVICE.	
Deputy Inspector General of Hospitals - -	1	Inspector General of Hospitals - - -	1
		Deputy Inspectors General of Hospitals - -	3
		Staff Surgeon Major in charge of a Circle - -	1
TOTAL - - -	1	TOTAL - - -	5
INDIAN SERVICE.		INDIAN SERVICE.	
Principal Inspector General - - - -	1	Inspector General of Hospitals - - -	1
Inspector General of Hospitals - - -	1	Deputy Inspectors General of Hospitals - -	6
Deputy Inspectors General of Hospitals - -	8		
TOTAL - - -	10	TOTAL - - -	7
BOMBAY.			
BRITISH SERVICE.		BRITISH SERVICE.	
Deputy Inspector General of Hospitals - -	1	Inspector General of Hospitals - - -	1
		Deputy Inspectors General of Hospitals - -	3
		Staff Surgeons Major in charge of Circles - -	2
TOTAL - - -	1	TOTAL - - -	6
INDIAN SERVICE.		INDIAN SERVICE.	
Principal Inspector General - - - -	1	Inspector General - - - -	1
Inspector General of Hospitals - - -	1	Deputy Inspectors General of Hospitals - -	4
Deputy Inspectors General of Hospitals - -	6		
TOTAL - - -	8	TOTAL - - -	5
ABSTRACT.			
British Medical Administrative Officers for all India, 1861 - -		5	
Ditto - - ditto - - ditto - - - 1869 - -		20	
Increase - - -		15	
Indian Service Medical Administrative Officers for all India, 1861 - -		33	
Ditto - - - ditto - - - ditto - - - 1869 - -		24	
Decrease - - -		9	
TOTAL Increase of Medical Administrative Officers - - -		6	

To this number should properly be added the Sanitary Commissioners under the Government of India, and the several Sanitary Commissioners in local Governments and Administrations.

The small numbers of Britons who had governed the Indian public under the EIC had relied on technology for communications and military clout, both of which were an assurance that they had the ‘right’, or even the ‘duty’, to police, arbitrate disputes, and demand deference.¹¹² I would argue that after 1858, with a larger number of Britons in India, social and cultural reforms were more easily (and more economically) achieved, and the establishment of a new institution, like the asylum, fell within the goals for this new imperial world.

We can compare the imperial world of India in 1858 with the imperial world of the Dutch East Indies after the First World War. Hans Pols has argued that colonial rigorousness was also required in the Dutch East Indies after war: the colonial government had attempted to end various attempts at independence and nationalism using repressive psychiatric measures. The professionalisation of nineteenth-century sciences such as phrenology and psychiatry were useful tools in this endeavour: in a society where scientific knowledge was the only kind of legitimate knowledge, the nature of the native voice – be it mutinous or other – could be scientifically deconstructed as an alienated intellectual, who was disconnected from his local community. This proved to be an efficient and strengthened kind of governance in the Dutch East Indies. Rather than expending time and resources to contain entire indigenous liberation efforts, the colonial government could simply throw the native leaders’ psyches into question, which would cap the movement altogether.¹¹³

¹¹² Michael Adas, *Machines as the Measure of Men: Science, Technology and Ideologies of Western Dominance* (Ithaca: Cornell University Press, 1989), 204.

¹¹³ Pols is very clear about the use of psychiatry as a powerful colonial ideology. “The Nature of the Native Mind: Contested Views of Dutch Colonial Psychiatrists in the former Dutch East Indies,” in *Psychiatry and Empire*, eds. Megan Vaughan and Sloan Mahone (London: Palgrave Macmillan, 2007), 190.

In India, however, these colonial tools were not used to stigmatize the leaders of the uprisings. Rather phrenology was part of the theoretical milieu in which a slow social and political reform occurred, in which the post-uprising world was contained. Psychiatry did not possess the disciplinary and professional clout in 1858 to instill “repressive measures” in India. Pols’ work in the Dutch East Indies comes much later in the colonial period, when psychiatry in Europe had developed stronger professional boundaries. There was no coherent psychiatric doctrine in 1858, certainly not a doctrine that could be applied to the colonial context. Secondly, asylums had not yet proven to be effective forms of colonial control (the practice of using the asylum as an archetypal form of colonial power was constructed in the early twentieth century). Thus, while the events of 1857 and 1858 flavoured the milieu that gave birth to the Lunacy Acts (not least in the necessity for reform), they were not catalysts. Translation of social reforms, from Britain to India, was seen as much more useful and cost-effective means with which to initiate a consolidated bureaucratic governance of India.

From Britain to India: Lunacy Laws

How small the interval – a hair’s breadth – between reason and madness.¹¹⁴

Anthony Ashley Cooper, the 7th Earl of Shaftesbury, is best known for his role as Chairman of the Commission in Lunacy in England at the passing of the 1845 Lunacy Acts. Lord Ashley was one of the new aristocratic Members of Parliament who participated in the Commission’s proceedings under the new Conservative government of Lord Peel in order to complete his training in Parliamentary business. He was initially

¹¹⁴ Quoted in E. Hodder, *The Life and Work of the 7th Earl of Shaftesbury* (London: Cassell & Company, 1892), II, 77.

part of the 1827 Select Committee of the House of Commons on Middlesex Pauper Lunatics, which preceded the Poor Law and was part of his growing agenda for charitable, benevolent reforms in Britain.¹¹⁵ He also had ties to the East India Company: he wrote to Robert Southey, poet laureate, in 1830 of his “weight and personal interest with the Directors of the East India Company” and his desire “to superintend the immediate comforts, and gradually to promote the civilisation [sic] of India.”¹¹⁶

Lord Cooper represented a number of British aristocrats who were aware of the number of asylums and other institutions that had grown as a consequence of the precepts set out in the Poor Law Act of 1834. The Poor Law had established workhouses for paupers, but many of those who entered these sites were simply sick, old or mentally ill, and the Victorian aspirations for the workhouses were never truly realized. There was a need to separate the vulnerable and the outcast from the “healthy” poor. From 1828, Lord Ashley’s Commission in Lunacy had been licensing and supervising private madhouses in London, but no legislation existed for state institutions.¹¹⁷ Lord Ashley wrote regularly in his diary of the treatment and care of the insane in these private institutions, and in 1838 he began to vociferously petition for better legislation in Parliament:

Gave a decision today along with colleagues, in the commission in Lunacy [...]. It is an unpleasant and responsible office either to detain or discharge a patient. In the first case you hazard the commission of cruelty to the prisoner; in the second

¹¹⁵ *Ibid.*, 89. He was associated with the repeal of the Corn Laws (import duty on grain) in 1846, the factory workers reform movement, and subsequently the leader of the evangelical movement within the Church of England.

¹¹⁶ Lord Ashley at Panshanger to Robert Southey at Keswick, in Hodder, *Life and Work*, II, 63.

¹¹⁷ Prior to 1828, anyone in England could obtain a license to open a private asylum, which meant asylum treatment was variable and abuse was not uncommon.

to his friends or the public. We can lay down no fixed rules for decision; we must take our course, according to doctor's prescriptions, *pro re nata*.¹¹⁸

By 1842, he had sponsored a licensed Lunatic Asylums Bill to inspect asylums in the counties, and not just the metropolitan areas, and instigated an Inquiry Commission to inspect the “treatment of Lunacy in England and Wales.”¹¹⁹

In 1845, the County Asylums Act and the Lunacy Act were introduced by Parliament, to affect the treatment and care of lunatics in England and Wales. Both Acts stated that there should be more purpose-built institutions to house and provide shelter for lunatics, and that these institutions be funded by the state. The Act also established a new Lunacy Commission, which had national authority over all asylums, and shared responsibility with the Poor Law Commission for pauper lunatics, who were to be moved from workhouses to public or private asylums. The Lunacy Commission also worked with Justices of the Peace in county asylums to collect data on the admission and discharge of patients from asylums, to advise on the development of lunacy law and policy. The asylums were required to keep records of these visiting “minutes,” or reports. Each asylum was also charged with appointing Official Visitors, who were either local men of good repute or members of other commissions in the area.

There had been non-legislative attempts to reform the asylums prior to 1845: Phillipe Pinel is often lauded as the first asylum superintendent to removing the shackles from his patients in Salpetriere and Bicetre asylums in Paris, while ‘moral treatment’ was invoked in 1796 in York by William Tuke.¹²⁰ Moral treatment was born out of religious

¹¹⁸ Diary Entry 3.10.1838, Hodder, *Life and Work*, 90.

¹¹⁹ 1842 Lunacy Inquiry Act (5 & 6 Vict., c. 87).

¹²⁰ Digby, *Madness, Morality and Medicine*, 4.

and social concerns for the well-being of asylum patients, and its central premise was to afford them the rights that they had lost with their diagnoses of insanity. Rather than using physical restraints and punishments, as in a prison, the patients were to be treated as morally accountable humans. In practice, many asylum superintendents could not provide such a service for inmates in their overcrowded institutions (Tuke's York Retreat was implemented with a patient population of just 30), and the 1845 Lunacy Act merely increased the population of asylums across the country.

It was with this legacy in mind that the Indian Lunacy Acts were passed in 1858, merely six weeks after the new government had taken its seat. They represented the thirty-fourth, thirty-fifth and thirty-sixth acts of governance under Crown Rule, and the first pan-Indian legislation addressing native lunacy in India. The new Government of India did not write the lunacy acts *de novo*; Acts 34-36 of 1858 were based in great measure on the English lunacy acts. The English acts had served to change the status of the mentally ill in England from criminal and poor, to patients. In theory, then, legislation for the new 'native' Indian asylums was meant to echo the psychiatric infrastructure of nineteenth-century Britain. Utilizing phrases borrowed from the mid-nineteenth century European asylum reformers, the lunacy acts discredited the idea of using restraint (such as chains and straitjackets) in Indian asylums, except for in very particular cases. The new laws also provided power to Court Magistrates and Police to detain any person suffering from insanity, after 'certification of lunacy' by a medical practitioner, however the exact definition of certification remained ambiguous and led to conflict over exactly who maintained authority over the diagnosis of insanity. The lunacy constituted three acts to represent the trifecta of Crown rule in India: one at the Supreme Court level in

Presidency towns, one at the District or local level in outlying territories, and one at the institutional level, for the care of lunatics in asylum spaces.¹²¹

These acts did not produce the kind of watershed moment in public imagination as had the English social and asylum reforms. It also did not provide impetus to what Foucault described as a Great Confinement in eighteenth and nineteenth-century Europe.¹²² What did they say, then? How was the new Government of India to manage lunacy? While the lunacy acts dance around the exact definition of madness, they were very clear as to what constituted a “lunatic”:

“The word ‘lunatic’, as used in this Act, unless the countary [sic] appears from the context, shall mean every person found by due course of law to be of unsound mind and incapable of managing his affairs... ‘Unsoundness of mind’ taken by itself is not sufficient to bring a person within the meaning of the term ‘lunatic’ as used in Act XXXV of 1858, unless it would incapacitate him from managing his affairs; nor on the other hand, will a person who is incapable of managing his affairs be a lunatic unless that incapacity is produced by unsoundness of mind.”¹²³

According to the new government of India, a lunatic was therefore not simply insane; he or she was also socially incapacitated in a particular way by this insanity.¹²⁴ A person suffering from lunatic symptoms who is still capable of “managing his affairs” would still have rights, according to local custom. Once unable to prove his social usefulness, he or she became a “lunatic”. Under the same rubric as the English Lunacy Acts, there was recognition in the courts and in the administration of the language of rights and customs that was critical to the entire political structure. However, these details were not explicitly

¹²¹ The Lunatics Act of 1858 (34 & 35 Vict., c. 22).

¹²² Foucault, *Madness and Civilization*, 27.

¹²³ Interpretation clause 23, Act XXXV, in Ghosh, *Probate, Minority, Lunacy and Certificate Acts*, 92.

¹²⁴ This echoes the *Arthashastra*, which determines an insane person as one behaving “in a manner likely to cause harm to the immediate neighbourhood” (my own emphasis). Quoted in Rangarajan, *Kautilya*, 370.

mentioned in the acts themselves, which defined a lunatic simply as “every person of unsound mind and every person being an idiot.”¹²⁵ It is interesting that in the act for the establishment of asylums (Act 36) the notion of incapacity was not explicit, whereas Acts 34 and 35, as used in the courts, do emphasise this detail. Once labeled a lunatic under Act 35, moreover, the presumption was that the person in question continued to be of unsound mind “until the contrary is shown” with the onus being on “those who assert it to prove that he was of sound mind”.¹²⁶

Incapacity can also be read in terms of consciousness. The Indian Penal Code, which was published a mere two years later, claimed that:

“nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law... If insanity is established, the accused person is found not guilty.”¹²⁷

Thus, knowledge -or lack thereof- could be used as a definite boundary between sanity (and, in the above quote, criminality) and lunacy. The definition was not always in place, however. Also, lunatics could arrive in several categories:

“Lunatics (According to the law in India) are either: Private Patients (who have friends or relatives willing to sign an admission order) or Public Patients (who are brought up by the police). Public Patients may be Civil (who are wandering at large, dangerous, etc., but have not committed themselves in any way before removal through the magistracy to an asylum) or Criminal (who have done some act which is against the law of the country).”¹²⁸

¹²⁵ The Lunatic Asylums Act of 1858 (36 Vict., c. 22), section 37, NAI.

¹²⁶ *Ibid.*, section 38, NAI.

¹²⁷ Act XXXXV of 1860, section 84, NAI.

¹²⁸ Quoted in Bryson, *Indian Lunacy Manual*, iii.

It was not clear if the category of Criminal Lunatic was usurped by the Indian Penal Code of 1860 (where the label of criminality cannot be put upon a legally defined insane person), and this may have added to the confusion between medical and legal jurisdiction at the administrative level.¹²⁹

The Asylums

Twelve state-funded native asylums were established under the new legislation.¹³⁰ Six already existed, in various parts of Northern India and under wildly different circumstances: Patna, Dacca, Murshidabad, Benares, Delhi and Bareilly. The other six – Nagpore, Jubbulpore, Lucknow, Dullunda, Moydapore and Cuttack – were converted from existing structures, such as large homes, and even a dilapidated farm.¹³¹

Patna Asylum was considered to be in the best condition of all of these sites at the time of the 1858 lunacy legislation. Based in northern Bengal, in what is now Bihar, it was a larger asylum than many of the other establishments, and suffered regular flooding on account of its proximity to the River Ganges. Patchy records for the asylum dated back to 1818, at which time it had had up to fifty patients. By 1858, however, it was filled with almost two hundred natives, most of whom were poor and homeless. As far as the records show, there was little therapy occurring at this site, and it is difficult to even attest as to whether a doctor or any medical staff were attached to the asylum.¹³²

¹²⁹ The next chapter will show how this confusion had no place in the asylums themselves.

¹³⁰ “European” asylums already existed in the subcontinent, dating from much earlier in the nineteenth century. The biggest of these, Bhowanipore, was located a few miles from Dullunda, and had often played host to ‘native’ insanes. Waltraud Ernst, *Mad Tales from the Raj*, 12.

¹³¹ “For the establishment of a new asylum in Bengal,” January 1859, Medical B, Home Department, NAI.

¹³² Medical Board to Lieutenant Governor, “Asylum at Patna,” Northwestern Provinces (hereafter NWP) Public Proceedings, December 1854, NAI.

The Benares Asylum, in contrast, had a recognized civil surgeon in charge. Located further inland, along the Ganges, the asylum housed up to 30 patients, most of whom were in Benares as part of religious pilgrimage. Civil Surgeon J. Leekie had taken control of the asylum in 1853 on account of an “alarmingly high death rate”. Although he described the asylum records as “very limited and incomplete”, he was one of the first surgeons to produce a statistical account of the native asylum. He ran the asylum much like a colonial hospital, admitting patients based on physical symptoms, and reflecting mainly on public health measures (such as access to clean river water, and the prevention of dysentery).¹³³

In contrast, the Delhi Asylum was run almost entirely as a colonial jail. It was located in the heart of the city, and the surgeon in charge – Surgeon G. Paton – had introduced some reforms of his own invention. Paton himself was very proud of his innovations, submitting an elaborate and boastful report about allowing considerably less food for those who were “idle, unwilling [and] unable to work.”¹³⁴ Paton boasted further that not a single patient had complained about the reduction in their diet, but this probably had more to do with the high death rate in the asylum than an acquiescence to Paton’s innovative system.

Bareilly, Murshidabad and Dacca had few contiguous records to demonstrate the length of their existence. One medical report insisted there had been an asylum at Dacca

¹³³ Benares is now Varanasi. Civil Surgeon to Medical Board, NWP Publ. Proc., June 1853, NAI.

¹³⁴ Civil Surgeon to Medical Board, NWP General. Proc., June 1853, NAI.

since the Mughal Empire, while another described the asylum as being a collection of houses that had recently opened its doors to the poor and unfortunate.¹³⁵

The heterogeneity of these pre-existing institutions adds to the layered theoretical backdrop to British-built state-funded native lunatic asylums of mid-century India. For the first time, the British government was responsible for funding and staffing these spaces, but they provided little else that was coherent. A menagerie of ideas and pre-existing structures manifested in the creation of these institutions, which were conceived under the rubric of novel legislation for native lunacy. The lack of any other harmonizing structure was testament to the disorganization of the new government and the absence of any particular ideological doctrine within the asylums. Andrew Scull and other revisionist historians of psychiatry would argue that the birth of the native asylum in India was a response by a beleaguered government to control and constrain the leaders of the 1857-8 uprisings.¹³⁶ Despite a great deal of literature to the contrary, nineteenth-century lunatic asylums have retained the legacy of being overcrowded custodial institutions, often no better than prisons.¹³⁷ However, my research strongly suggests that these twelve institutions (and a second wave of asylums established in the 1860s) were not part of any grand hegemonic or colonial scheme. Instead, they were the inevitable product of a hastily assembled set of lunacy laws, which had themselves been borrowed from England instead of being written specifically for this colonial setting.

¹³⁵ India Publ. D., August 1852, NAI.

¹³⁶ Stanley Cohen and Andrew Scull (eds.), *Social control and the State: historical and comparative essays* (Oxford: M. Robertson, 1983), 40-44.

¹³⁷ The radical and revisionist histories of the 1960s and 1970s continue to hold sway over our historical imagination, e.g. Michel Foucault, *Madness and Civilization*, 1967; Erving Goffman, *Asylums*, 1961; David Rothman, *Discovery of the Asylum*, 1971.

In the next chapter I will show how the asylum functioned within the community, drawing upon local and British belief systems of how to manage the insane. The ecology of the asylum was different, depending on the communities and geography of each individual institution. The colourful ways in which local communities assimilated and appropriated the asylum affected the practices therein, and suggests a degree of permeability to the insane asylum not previously seen in comparable institutions in Europe or other colonial asylums in the British Empire.

Chapter 2: Everyday Life: Wallahs, Families and Communities

In 1870, a British medical officer and Official Visitor at several asylums in the Bengal Presidency, Dr. Edwards, wrote of a patient in the Calcutta Medical Gazette. Without a professional organ for alienists or psychiatrists in India, the various medical gazettes (Calcutta, Bombay, Madras and Indian) were the commonest outlets for ruminations on lunacy in the subcontinent. Regular exposure to native lunacy had put white insanity into perspective for Dr Edwards. He wrote:

“I cannot understand the language and life Mannu leads. Labelled a violent insane, he has caused little trouble once he arrived. That which I took as evidence of his lunacy was, when visited by his father [...] normal behaviour. It cannot be that entire families are insane, even allowing for the hereditary nature of many diseases of the mind [...]. In talking with his father, I agreed to give Mannu a small garden plot. Working with his hands, renders him less liable to babbling and spitting [...].”¹³⁸

On the one hand, Edwards did not “understand” Mannu: Mannu’s behaviour was not considered abnormal by his Indian family, and yet British categories of madness would label him a “violent insane.”¹³⁹ On the other hand, Edwards was in agreement with Mannu’s father: the notion of outdoor work, tending a garden, and establishing an occupation or routine was familiar. Moreover, “babbling and spitting” were evidence for Edwards of Mannu’s affliction. How did Edwards navigate this hybrid presentation of insanity, which was partly conventional and partly unfamiliar? How to resolve his

¹³⁸ Surgeon-General Edwards, M.D., “Correspondence comprising the Lunacy Acts, and the statutes relating to criminal lunatics, and the asylums officers’ super annuation act,” *Calcutta Medical Gazette*, 1870, 326, BL.

¹³⁹ Categories of madness in the nineteenth century were neither absolute nor constant. The category of violent insane was taken directly from European psychiatry, and was a common diagnosis for any patient who behaved violently on admission. Until Emil Kraepelin’s diagnostic categories at the turn of the twentieth century, psychiatry did not possess a common and consistent diagnostic vocabulary. Eric J. Engstrom and Matthias M. Weber, “Making Kraepelin history: a great instauration?” *History of Psychiatry* 18, 3 (September 2007): 267-273.

ambivalence towards Mannu's diagnosis and his commitment to the native lunatic asylum?

Edwards later became Inspector General of Hospitals in Bombay, and his new role permitted him less time to interact with asylum communities in the Presidency. Nonetheless, he continued to ruminate on the idea of 'native lunacy.' He wrote in a letter to his wife that British "lunatics in England manifest less of the depravity or insanity that is so rife amongst these natives."¹⁴⁰ In other words, Edwards felt the nature of lunacy in England and India was comparable; 'native lunacy' was more extreme or of a more severe nature than 'English lunacy'. The relative nature of insanity is one of many ideas we can glean from Edwards' writings. As asylum superintendents and other British staff in Indian asylums had not organized into professional groups with professional publications in the nineteenth century, examining the writings by Official Visitors in other capacities (such as in gazettes, or personal correspondence) is one means of accessing the daily, local experiences of life within a native lunatic asylum. We can also examine each asylum's Annual Reports, which were collected and published initially alongside the medical reports of each presidency, and then, by 1880, also summarized in the medical journals.¹⁴¹ By coupling these Reports with articles from the vernacular press, where available, we can begin to reconstruct a picture of the colonial asylum steeped in its local ecology.

¹⁴⁰ Despite his enlightened view of white insanes, Edwards himself never followed up these ideas with identifiable action. Letter to Beatrice, File no.4/10, WL.

¹⁴¹ The earliest native asylum reports in British India date from 1822: Lieutenant-Colonel W.H. Sykes, "Statistics of the Hospitals for the Insane under the Bengal Presidency," *Journal of the Statistical Society* viii (1830): 58-65. Sykes discusses the mortality rate for the Insane Hospital since 1818 as being almost 90 percent, while the Madras Lunatic Asylum is mentioned as having treated 77 patients in 1843.

Edwards' writings also show how local families emerged as critical actors in these asylums, very unlike the other colonial institutions in British India in this period. Mannu's father provided information on how the asylum staff might provide therapeutic relief for his son, and there is ample documentary evidence that this was common practice in these mid-century native asylums. This is just one of the many ways in which native asylums were not typical of colonial institutions in India. Native prisons rarely admitted visits from inmates' families, and medical hospitals were sought out by local families precisely for their Westernized paradigms of treatment.¹⁴² The well-populated "pauper asylums" in Europe rarely sought or acknowledged advice from patients' families, and colonial prisons did not admit visits by inmates' families. Mannu's father's suggestion for working in the asylum gardens echoes the moral therapy that occurred in some European asylums, but these ideas do not stem from the same philosophy. Whereas William Tuke and the other moral reformers in England tried to create a system where daily chores were rewarded, Tuke and Kirkbride's visions of moral therapy were not translated to the way the native asylums in India treated their patients. Native patients were not moved closer to the entrance of the asylum for good behaviour, for example, because native asylum architecture did not permit this maneuver. Mannu's father's therapeutic agenda was well-received by the British medical officers because of how familiar the treatment seemed to them, but Mannu's father was not trained in Westernized

¹⁴² Local families who were invested in indigenous or familiar therapies sought out local healers, such as *vaidyas* and *hakims*. So much so, that by the end of the century, doctors in medical hospitals in India actively recruited such healers to act as in-house locums. If British officers were sensitive to caste taboos and local concerns over women in public spaces, they also recruited high-caste or even female medical staff to encourage families to enter these colonial medical spaces. Kumari Jayawardena has argued this was a strategic maneuver, exploiting traditional norms to strong-arm Indian communities into participating with the colonial regime. See *The White Woman's Other Burden: Western Women and South Asia during British Colonial Rule* (New York: Routledge, 1995), 40.

paradigms of cultivating rationality or moral autonomy.¹⁴³ The fact that treating Mannu in this way was acceptable to both Mannu's father and the British asylum staff suggests the asylum was tolerant towards many ideas, not only those belonging to Western psychiatry. The hybrid environment of the native lunatic asylum will be explored further in this chapter.

From this small anecdote, we can begin to recover the everyday life of the native asylum in mid-nineteenth-century India. We see the familiar and familial interactions between British staff, local families and admitted patients, we learn of therapies that can be accommodated by many different ideologies of madness, and we conclude that the asylum was a dynamic and permeable site for multiple actors in this colonial **world**.

This chapter examines a variety of sources to uncover daily life within British-built 'native' asylums at a very tangible, informal and even mundane level. Looking at a handful of the asylums that emerged after the Lunacy Acts of 1858, I hope to illuminate the ways that a variety of actors interacted with each other and negotiated the meaning of insanity. Examining the place of the asylum – a new colonial institution – within the local community reveals how the community was an integral part of the asylum and the colonial government functioning at the ground level. As a variety of Indian and British actors become visible as constituting a rather heterogeneous space, I will intimate the presence of a hybridized system of treatment that borrowed from local, religious, state and colonial beliefs about madness. This chapter is especially concerned with those actors who are traditionally left out of the asylum records: asylum attendants, families and local community members. The presence of these non-traditional asylum actors

¹⁴³ For more detail about the history of moral reform in British psychiatry, see Digby, *Madness, Morality and Medicine*, 1985.

allows me to argue for the permeability of the native lunatic asylum in India, and for the utility of the asylum in reframing a number of questions in South Asian history.

The evidence for these non-traditional asylum actors comes primarily from the annual Asylum Reports, the vernacular press, and correspondence between British staff and administration. Many of the official visitors bemoaned the lack of *in situ* psychiatric expertise, and superintendents reflected upon the ideas suggested by their inferiors: the cooks, janitors, cleaners and asylum attendants, who had been recruited from the local community. These ideas were not consistent across the entire asylum network; their appearance in the historical record reveals the idiosyncrasies of a variety of actors at each individual asylum.

In order to layer different kinds of archival sources together, I borrow the methodologies demonstrated in a recent feminist history anthology, *Contesting Archives*.¹⁴⁴ With the archived annual reports, official records and unofficial correspondence all representing the contours of power in colonial India, there are several challenges in trying to write a history that documents and interprets the lives of those excluded or hidden from positions of power. While *Contesting Archives* prioritizes locating different kinds of women in the historical record, the methodologies employed are nonetheless pertinent to locating the hidden voices of the asylum community. “Researching around” particular sources, reading materials “against the grain,” weaving together different layers of information, and using absences and knowledge of the context are all useful strategies that I employ in this chapter.

¹⁴⁴ Nupur Chaudhuri et al., *Contesting Archives: Finding Women in the Sources* (Urbana: University of Illinois Press, 2010), 3.

For example, I read against the dominant voice in the Annual Report for Vaccinations, Charitable Dispensaries and Lunatic Asylums in Bengal in 1880 to establish the names, places and events of a therapeutic ‘experiment’ in tempering the spiciness of food in Dullunda Asylum. Researching these names and events in subsequent annual reports and the vernacular press at the time revealed local disdain for the lack of spice trade from the local bazaar. Layering the correspondence of the asylum superintendent on top of this foundation permitted a connection to the recruitment of two new janitors and attendants, which in turn raised questions about the origin of the idea to reduce insanity by a reduction in spice.¹⁴⁵ Humoral treatment of this kind was not always found in each asylum: sometimes it was implemented by asylum attendants, who bathed their charges more regularly and, on several occasions, provided *haldi* (turmeric paste) via cooked food or applied to specific parts of the bodies.¹⁴⁶ Visitor books from each asylum were not found, but references to them in the asylum reports revealed that some asylums received regular visits from missionaries, who championed certain moral tropes of Western psychiatry through their belief in the healing power of Christian prayer and God's forgiveness. Finally, families appear, like in the anecdote above, in correspondence, legal proceedings and asylum admissions, describing their reasons for committing a relative to the asylum: from physical trauma, such as being dropped on his

¹⁴⁵ This carefully reconstructed history is detailed later in this chapter.

¹⁴⁶ Turmeric has a lengthy legacy in the subcontinent – its popularity in savoury foodstuffs, its use as a dye, its vogue in many religious ceremonies, and its presence in Ayurvedic medicines, all contribute to its social, cultural, religious and economic significance in India and Pakistan. It would be impossible to provide a thorough list of the most recent scholarly works on this substance, however it is regularly acknowledged in histories of Ayurvedic medicines, studies into “non-Western” herbal remedies, biological examinations of plant chemistry, and ethnographic studies of Southern India.

head as a child, to the immorality of his mother, or his forgetting to follow appropriate hygiene standards during a particular religious festival.¹⁴⁷

Beyond the asylum's resident population – differentiated as it was between British officers, local Indian staff, and the caste and class of the patients – the asylum walls were regularly traversed by members of the local community. Local tea sellers (*chai wallahs*) entered the asylums to sell tea to the guardsmen and administrative staff, village elders visited to negotiate the use of land, laundry-men (*dhobis*) carried clean and dirty clothing to and from the building, and local musicians and dancing women arrived once or twice a month to perform dance or musical *nautches*.¹⁴⁸ In these ways, the everyday life of the local community extended into the asylum. Spiritual *gurus* and religious men often visited the asylums to mark holy days and enact primarily Hindu rites, although Christian missionaries also visited these institutions. Logistically, the asylum provided employment, not only in recruiting attendants but also by hiring temporary workers (builders, plumbers, etc.) from the surrounding towns and villages. Land prices in the greater community must have been affected by the success of an economically useful institution. Reframing the asylum as a useful addition to the community required the interest and involvement of Indian people who were not direct employees of the colonial administration, and challenges much of the historiography that suggests lunatic asylums were stigmatized and stigmatizing institutions.

¹⁴⁷ Most of the admissions stories revolve around male patients; women are found less often in these asylums, and their presence is rarely accompanied by familial support.

¹⁴⁸ *Annual Report of the Insane Asylums in Bengal for the Year 1862* (Calcutta: Bengal Secretariat Office, 1863), NAI.

There are three sections in this chapter: the visibility and variability of communities which, by nature of the modern archive, do not appear very often in the historical record; the hybridity inherent to asylum practice, including the creation of novel institutional roles; and the permeability of the asylum, embedded in local everyday life. In what follows, I examine the Indian staff and tea sellers who were actively recruited by the state to serve the asylum. I consider two attendants, Darogah Gilson and Old Babu, unusual in being named in the historical record, and whose stories reveal the positive and negative relationships between asylum and community. The second part of this chapter looks at the familial context: why were families invested in the asylum, and which familial tropes became integral to the asylum? Finally I look at the ‘sub-official realm’, the administrative arm of the asylum, inhabited by secretaries and officers located far from the physical locus of the institutions. I suggest that the permeability of local belief systems extended upwards, beyond the walls of the asylum, through the sub-official network of administration, to affect official practices in asylum management.

Wallahs, Warders and Keepers

The staff employed to work in the asylums were, out of necessity, recruited from the local communities surrounding each asylum. Janitors, cooks and attendants were Indian, while the asylum superintendent and his administrators were English.¹⁴⁹ Day-to-day care of the inmates was supervised not by the British, but the Indian staff. The Indian attendants exercised the most significant influence over patients, even though instructions for patient care were made at the level of the state government. In this context, local ideas

¹⁴⁹ This was a long-standing practice, which was economically efficient, especially in the aftermath of the 1850s uprisings. *Triennial Report on the Lunatic Asylums of Bengal for the Years 1906, 1907 and 1908* (Calcutta: The Bengal Secretariat Book Depot, 1909), BL.

of managing the insane, as provided by the attendants (and janitors, etc.), were able to commingle with any extant Western psychiatric beliefs.¹⁵⁰ Patients and doctors represent the most prominent actors in the colonial asylum. The asylum existed to ‘treat’ insane natives, and it was primarily doctors (asylum superintendents, medical officers, etc.) who were charged with treating them. When patients arrived in the asylum, they were officially given a diagnosis. This was usually a simple description of how they had been found – e.g. “ganja-smoking [...] wanderer”, “melancholic, no family”, “low-caste labourer, manic” – but these diagnoses, based mainly on Western psychiatric labels, meant very little once the patient was in the asylum.¹⁵¹ In fact, most of the patients reorganized themselves along caste, class or lines of employment once inside the asylum, and very little treatment was given under the auspices of Western psychiatry.¹⁵² We glean such information from the notes and letters preceding annual reports in the archives, which detail the extraordinary roles played by other actors in organizing, managing and caring for the insane.

In 1872, the asylum at Delhi undertook some restructuring, both in buildings and in employees. The Inspector-General of Hospitals in the area, Dr. Tresidder, made several remarks about who had been recruited:

¹⁵⁰ We see this commingling in Dr. Edwards’ description of Mannu and his father’s belief system, earlier in this chapter.

¹⁵¹ A.C.C. DeRenzy, Esq., Deputy-Surgeon-General, Dacca Circle, *Report on the Tezpur Lunatic Asylum 1877* (Shillong: Assam Secretariat Press 1878), BL.

¹⁵² Kim Wagner’s study of phrenology in colonial India speaks to the way in which nineteenth-century British categories tended to group all Muslims and all Hindus as mutually exclusive subjects. Wagner describes how “Hindus and Muslims would [...] eat separately but drink and smoke together. Not to say that caste and religious divisions were non-existent, but rather they were flexible and that different norms took precedence depending on practical needs and circumstances”. In Wagner, “Confessions of a Skull,” 31.

In place of the discharged Jemadar,¹⁵³ I have appointed a man called Peer Bux, a very respectable Mahomedan, who is especially valuable, as he has a certain amount of medical knowledge from having been a Native Doctor in [the community]. There is not enough medical personnel whatsoever and this is needed, although I do hope that if a Native Doctor be appointed, this appointment will not interfere with Mr. Gilson [the Darogah] whose exceeding care, judgment and kindness would, if lost to the Asylum, be ill compensated for by the services of a Native Hospital Assistant.¹⁵⁴

This quote reveals to us several kinds of attendants: Jemadars, Native Doctors, Darogahs and Hospital Assistants. While Dr. Tresiddar was concerned about the quantity and quality of ‘medical’ expertise present in the asylum, it seems that his priority was “care, judgment and kindness”, which were not rendered exclusive to the role of the Darogah in the asylum. The following year, in the government’s 1873 Statement of Newspapers, we find that the recruitment of an interfering Native Hospital did occur, much to the chagrin of Dr. Tresidder, and the existing asylum attendants.

Chardalaka [sic]: The new Pagla Doctor, Gurinder, has been in the asylum for six months. He has been in disagreement with Darogah Mister Gilson. Now that three patients have died, he has removed two keepers from employment. Mister Gilson is much loved by the Asylum and, even if Gurinder must leave in order to do so, his men would like him to stay.¹⁵⁵

Even within the asylum, then, conflict existed: the attendants working under Mr Gilson preferred the asylum without the new Native Doctor, Gurinder, not least because he had fired two of them during his residency. We know little of the Native Doctor, excepting this newspaper excerpt. His name is typically Punjabi (especially compared to Gilson), so the keepers’ dislike of him does not stem from ethnic prejudice.

¹⁵³ *Jemadar* was a rank used in the British Indian Army to describe men who assisted their British commander, filling regimental positions. As the British Raj took over the running of public or state-funded asylums, many military men were recruited to their organization and management.

¹⁵⁴ Letter No. 127, 22 February 1873, Dehli [sic] Division –March, Nos. 51-52, *Annual Report on the Lunatic Asylums in the Punjab for 1872*, Home Department, Medical Branch, 1874, NAI, 8.

¹⁵⁵ Statement of Newspapers, Punjab, 1873, BL.

One of the groups in the asylum that is most often obscured by the historical record is the asylums keepers and attendants, or ‘wallahs’. A *wallah* is the term used to describe a person concerned or involved with a specified thing or business; for example, a *chai wallah* describes a young man who sells tea (*chai*). *Wallah* can also be a native or inhabitant of a specified place, as in *Bombay wallah* for an inhabitant of Bombay, or *pagla wallah* for someone living around the asylum.¹⁵⁶ The word comes originally from the Hindi suffix *-vala* (‘doer’ or ‘fellow’), which in turn comes from the Sanskrit *palaka*, or ‘keeper’.¹⁵⁷ The chai wallahs visited asylums and other institutions (prisons, banks, courtrooms) on a regular basis, carrying tea and gossip; their innocuous roles in society meant they were able to traverse very disparate spaces, such as private homes and official buildings, without causing offense.¹⁵⁸ This section will consider the pagla wallahs, the men who worked in the asylum as attendants (*wallah* as ‘keeper’), the chai wallahs who visited daily¹⁵⁹, and those men and women who visited the asylum from the local

¹⁵⁶ *Pagla* is the masculine adjective for insanity. *Pagla ghar* was often used as a phrase in the Hindi-speaking regions of India to describe the asylum. In Bengali, where rhyming slang was often invoked, the asylum was often described as a *paglee baree*, using the feminine adjective for insanity to rhyme with the Bengali word for house.

¹⁵⁷ R. S. McGregor (ed.), *The Oxford Hindi-English Dictionary* (New Delhi: Oxford University Press, 1997), 915.

¹⁵⁸ The history and dominance of tea in Indian culture is far too expansive to summarize here. However, tea plants have been native to East and South Asia for millennia, and drinking tea has been a common practice in Assam and the Northeast of India for almost as long. The Dutch and British East India Companies began their trading monopolies in the subcontinent to capitalize on tea production and consumption. See Colleen Taylor Sen, *Food Culture in India* (Connecticut: Greenwood Press, 2004), 19-27; E.M. Jacobs, *In Pursuit of Pepper and Tea: The Story of the Dutch East India Company* (Amsterdam: Netherlands Maritime Museum, 2009); Alan Macfarlane and Iris Macfarlane, *The Empire of Tea: the remarkable history of the plant that took over the world* (Woodstock, NY: Overlook Press, 2004); Jane Pettigrew, *A Social History of Tea* (London: National Trust, 2001).

¹⁵⁹ It might be possible to perform the same exercise using the *dhobis*, the laundry men who were often recruited to clean the clothes of homes and institutions alike. However, dhobis appear in the historical record even less than the chai wallahs, so this may prove difficult. Dhobis preceded modern professional dry-cleaners. In the nineteenth-century, they would have accessed the asylums through the side entrances, and had little contact with the British staff (who left the historical record we rely upon). Moreover, as

community (*wallah* as inhabitants of a specified place). There was a great deal of discussion about these wallahs in the official, sub-official and local literature. Most of the discussion revolved around their recruitment, their pay, and the kind of work they should be expected to do. With an asylum community so extensive and variable, these discussions did not always reach a conclusion, and many negotiations took place.

The chai wallahs sold their services not only to the people waiting in the reception area of the asylum, but also to the doctors and British staff occupying the bureaucratic and colonial administrative spaces, as well as to the patients in the more private areas of the asylum, in patients' rooms and in the asylum's central courtyard. Some of these men had more access to the asylum than most of the British staff. They exchanged gossip along with their wares, took messages, brought local newspapers and even discussed recent social and political events.

At Lucknow Asylum, established in what is now called Uttar Pradesh, the visitor books show a number of chai wallahs visiting more than forty-five times across the month of May 1865.¹⁶⁰ Mr O'Callaghan, the Inspector General of Hospitals in the region, wrote in a letter to his friend that:

How talkative are the wallahs when they come with their tea. Even though I understand only limited Hindustani, they talk as if I am an old friend... One wallah has improved his English immeasurably through our daily interactions. He told me about the construction of a new madhouse to the North, whose establishment would take funds away from our great public asylum... [which]

asylums became more self-sufficient, many of the patients would have been encouraged to wash their own linen, as a form of occupational therapy, instead of relying upon the dhobis. There are few studies on the class and caste of men who comprised the dhobis, e.g. Lucy Norris, "Dhobighat", *Visual Anthropology Review* 21, 1-2 (March 2005): 168-179.

¹⁶⁰ This is approximately three visits every two days, which seems an excessive amount, until you consider the prevalence of tea within British and Indian culture. *General Report on the Lunatic Asylums, Vaccination and Dispensaries in the Bengal Presidency 1865* (Calcutta: Office of Superintendent of Government Printing, 1866), BL.

already provides an important custodial role for the very vulnerable insanes in this country.¹⁶¹

O'Callaghan's words suggest a close interaction between the natives and the more powerful colonial government: O'Callaghan represented the state, and yet he was on very familiar terms with these wallahs. This letter also points at O'Callaghan's dependency on these local men for information about the very government he represented. Official correspondence between the Officiating Secretary and several interested parties show that the local government was considering the construction of another asylum to cater to high-caste or Eurasian patients.¹⁶² As a result of this tidbit of information, O'Callaghan was able to successfully petition to the Government of India against the construction of another asylum in Oudh, suggesting "one large asylum is sufficient for the whole province"¹⁶³. With the aid of the chai wallahs, O'Callaghan redirected some of the allotted funds to his asylum in Lucknow and effectively reified his own position. The wallahs had rendered the asylum walls more permeable to the ideas and activities occurring beyond Lucknow. This vignette also suggests at the utility of asylum life to British officers and colonial representatives at a very informal level, in much the same way as it was useful to the local community. The asylum was not an isolated space, or

¹⁶¹ Correspondence, R.D. O'Callaghan, Inspector General of Hospitals, Lucknow, Indian Medical Department to Major-General H.W. Norman, C.B., Military Department, 5 August 1865, BL.

¹⁶² Correspondence, Surgeon-Major J.T.C. Ross, Officiating Secretary to Inspector General of Hospitals, Fort William, 11 July 1865, BL. I cannot conceive that this asylum was planned due to demand by local communities. I imagine that the lack (albeit not absence) of high-caste patients in these asylums triggered the administration into assuming this was an issue of purity. It is more likely that higher caste insanes were kept at home, regardless of the institutional help available to them. Karen I. Leonard, among others, has written extensively on caste and caste practices in India: *Social History of an Indian Caste: The Kayasths of Hyderabad* (London: Orient BlackSwan, 1994); see also Nandini Sundar, "Caste as Census Category: Implications for Sociology," *Current Sociology* 48, 3 (July 2000): 111-126.

¹⁶³ Correspondence, R.D. O'Callaghan, to E.C. Bayley, 13 September 1865, BL.

simply an appropriated space; it was an increasingly permeable and useful technology for understanding and participating in colonial India, officially and informally.

The superintendents and their administrative staff were required to hire attendants as needed. Recruiting attendants, of any kind, often resulted in angst at the institutional, administrative and local levels. In 1870, there was an overarching concern that the native assistants in the asylums were being recruited under the same Sub-Assistant Surgeon rank as English-educated men.¹⁶⁴ In 1910, “following the practice in Bengal lunatic asylums of providing extra attendants for paying patients at the cost of their friends,” the asylum in Uttar Pradesh sought to recruit more wallahs for the patients in their asylums.¹⁶⁵ This presented several problems. Firstly, the new attendants had no place to stay – while the Bengal asylum at which this practice had occurred was large enough to accommodate new staff, the Uttar Pradesh asylum had limited space. In a rare letter from one of the Native Doctors to an administrative friend in Calcutta, we find out that “the asylum is too busy for anyone to make sense” and “the close proximity of living quarters has created arguments between the wallahs, some of them complaining the new keepers make the rooms smell.”¹⁶⁶ The wage structure and lack of space meant that the new asylum attendants rapidly changed the system already in place, and this disruption was also felt by the administration.

¹⁶⁴ *Conditions under which the rank of Sub-Assistant Surgeon should be bestowed up on Hospital Assistants*, Home Department, Public, 1 December 1870, Nos. 45-46, NAI.

¹⁶⁵ *Entertainment of extra attendants for paying patients by the Superintendents of Lunatic Asylums at the cost of patients' friends*, Home Department, Medical A, February 1910, 36-37, NAI.

¹⁶⁶ Correspondence, 25 November 1909, BL.

The administration tried to deal with the problem of extra attendants in a few ways: by seeking out precedents in asylums in Bengal, and by establishing who had authority over these new employees:

Under rule 51 of the rules for the control and management of lunatic asylums in Bengal,¹⁶⁷ extra attendants for paying patients in such asylums may be entertained by superintendents in Uttar Pradesh at the cost of the patients' friends... It is not possible to prescribe a standard scale for the employment of such attendants, and thereby to regularize the authority given to the superintendents of asylums. The qualifications and remuneration of such men may obviously vary in different cases, and must be mainly regulated by the amounts which the friends of the patients are willing to pay. In the opinion of the Lieutenant-Governor the matter is essentially one in which a discretion should be left to the local superintendents, provided that the cost of the additional staff [...] does not fall upon Government.¹⁶⁸

Essentially, this was a problem of layered authority:¹⁶⁹ the superintendent had local jurisdiction over recruitment in the asylum, but his authority lay under the jurisdiction of the local government, which in turn had to acquiesce to decisions made by the Government of India. There was also a problem of what to call these extra attendants:

Superintendents of asylums employ, as occasion requires, extra servants for such patients at the cost of their friends. The amounts so received are paid into the treasury, and the wages of these extra servants are drawn on supplementary abstract bills... The Accountant-General now points out that these extra attendants should be treated as temporary Government servants and that their entertainment by the superintendents constitutes a re-delegation to a subordinate authority of the power of sanction vested in the local Government, which requires the sanction of the Government of India.¹⁷⁰

¹⁶⁷ "Extra attendants for paying patients may be entertained by the Superintendent at the cost of the patient's friends. The wages of such attendants will be drawn from the local treasury in abstract bills, or paid from permanent advance; and all money received on account of servants from friends of lunatics will be credited under asylum receipts and paid into the treasury. In no case can payment from a patient to a fixed servant of an asylum be permitted." Quoted in V/2/349, BL, 2.

¹⁶⁸ Correspondence, H. Wheeler, Esq., CIE, ICS, Secretary to the Government, Municipal (Medical Department) to the Secretary to the Government of India, Home Department, no. 4282-Ex, BL, 4.

¹⁶⁹ This was similar to the layered sovereignty that was seen across the subcontinent, from Mughal rule through to the Company and Raj.

¹⁷⁰ Correspondence, Colonel R. Macrae, MB, IMS, Inspector-General of Civil Hospitals, Bengal, to the Secretary to the Government of Bengal, Municipal (Medical) Department, NAI.

If the new wallahs were considered servants of the patients, then their entire costs would be paid for by the patients' friends. If however, they were considered 'temporary Government servants', then their affiliation to asylum would not be indirect through the patient, but would directly connect them to being employees of the Government, and subject to the same expectations and benefits. The fact that discretion for these choices usually fell "to the local superintendents," is telling. Ultimately, the colonial administration wanted "indirect rule", not having to micro-manage every aspect of their dominance. This meant relying upon local governments and individual superintendents to make the most effective choice, on site, within their specific asylums. However, local superintendents might not be very local at all – only a handful of British staff resided at the asylum; overnight the asylums were entirely under the authority of the wallahs. There were offices and bureaucratic spaces for the British staff, but many of the keepers slept in the verandahs of the asylums each evening. As such, the local men, the newly-recruited and existing wallahs, were given responsibility for this institution, and this probably fed into the angst felt by superintendents upon recruiting them.

Related to this recruitment angst was the consternation over what kind of wallah should be recruited to asylums. The differences between prison and asylum wallahs reflected the administrative differences between medical and penal spheres of colonial administration.¹⁷¹ For example, in 1886, Burma was very much under British colonial rule, with many Indians arriving as soldiers, administrators, construction workers and traders. Burmese asylums fell under the same rubric as asylums built in India, and many

¹⁷¹ The various ways medical and penal spheres of colonial administration interacted in the asylum is the subject of chapter 4.

Indians lived in Burma as comfortably as they lived on their native soil. The superintendent of the Lunatic Asylum in Rangoon (now known as Yangon) was, unusually, Indian and he experienced similar angst to his European counterparts in India:

All the keepers without exception are natives of India, and only a few of them care to stay in their appointments for any length of time... At present, there is no age-limit as regards the keeper staff. Keepers who are, I have considered, too old and feeble to render further useful service have been invalided. Though according to the Asylum Rules, it is apparently permissible for me to fix an age-limit, I would prefer that this be done by [the Inspector-General of Civil Hospitals, Burma], and would suggest that 55 years be made the age of compulsory retirement. This would allow a man entertained at 25 years to complete thirty years' service and qualify for pension.¹⁷²

Superintendent Singh had managed to permeate the asylum community so far as to manage the degree to which his own asylum was permeable to the Burmese community. Singh clearly privileged Indian wallahs over the natives of Burma, and was not invested in practicing the same porosity as seen in the UP asylum at this time. Singh's concern for the kind of 'keeper' employed at his asylum reveals a real reflection over the nature of his job and the role of his institution in this annexed land:

I hope that you will see... there is the continual risk of injury by dangerous inmates to be considered and the care of the insane demands from a keeper an amount of self-control and tact which is not required of jail warders or nursing orderlies in hospitals, and which is not likely to be found in the lowest class of applicant. The keeper staff is the backbone of an asylum and the qualities of character of individual keepers are more important to the patient's welfare than are those of the member of the superior staff with whom they are not constantly associated. When the wallahs of the Bombay, Lahore and Agra Asylums drawing above Rs.10 per mensem and who are recruited locally are classed as being in superior service, I am unable to understand why such concessions should not be extended to the asylum keepers here.¹⁷³

¹⁷² Correspondence: Letter no. 439 P.C., 10 March 1910, from W.S.J. Singh, IMS, Superintendent, Lunatic Asylum, Rangoon, to the Inspector-General of Civil Hospitals, Burma; Home Department, Medical A, November 1910, Nos. 78-79, NAI.

¹⁷³ *Ibid.*, No. 79.

In Uttar Pradesh and in Burma, events that occurred at the ground fact gradually ascended the administrative ladder of British bureaucracy to affect other asylums and practices. In Burma, Superintendent Singh was able to use his knowledge of Bombay, Lahore and Agra asylums to petition for higher wages in Burmese asylums. In Uttar Pradesh, “entertaining” extra attendants in asylums was “a procedure of long standing”. This was a “procedure” that began, in situ, at the turn of the century, in specific asylums. By 1910, a scheme that had begun by patients’ friends and families in a very subaltern fashion, was gradually fortified and made ‘official’ by the Government of India. The local community had expanded into the colonial administration. The friends, communities and wallahs were important practically on the ground in the asylums, but were significant also in the way the colonial system was run. This was indeed a “re-delegation of the power of sanction vested in the local Government.”

The notion of the British state extracting political intelligence and information from local communities is not new. Christopher Bayly’s analysis of British colonialism during the first two thirds of the nineteenth century reconceptualized a shifting “information order” in north India.¹⁷⁴ Bayly’s monograph is less concerned with intelligence in terms of ‘spying’, and more concerned with social communication.¹⁷⁵ Initial efforts to gain information were impeded by Orientalist attitudes towards Indian culture, which underestimated the value of local people and local knowledge, and prevented British officers from realizing Western rule was unappealing to their subjects.

¹⁷⁴ Bayly, *Empire and Information*, 3.

¹⁷⁵ Jürgen Habermas, *Communication and the Evolution of Society*, trans. Thomas McCarthy (Boston: Beacon Press, 1979); *idem.*, *The Structural Transformation of the Public Sphere: an inquiry into a category of bourgeois society*, trans. Thomas Burger and Frederick Lawrence (Cambridge: MIT Press, 1989). Bayly acknowledges the British resorted to traditional intelligence gathering both during and after the events of 1857 and 1858.

Only after the military disasters in Afghanistan in 1842 did the British government realise the benefits of intellectual debate with their subjects about geography, language, astronomy and medicine. Bayly's analysis raises interesting questions about those elites who balanced precariously between promoting colonial science as a quest for pure knowledge in their midst and participating in the British search for power. It also raises questions for what British asylum superintendents to be their purpose at the helm of these asylums; as undistinguished men in a large imperial workforce, they were in no doubt of their unimportance in the middle of the century. As I describe in a later chapter, they gradually acquired the status of an expert, but whether they believed they were also practicing colonial governance or hegemony is not known.

Psychiatry was not yet a coherent discipline that could be debated in the subcontinent.¹⁷⁶ However, as the case of the Uttar Pradesh asylum shows, the chai wallahs were essential to imperial officers learning information about their own empire. The chai wallahs were not part of India's intellectual milieu, and nor were many of these asylum superintendents; however Bayly's premise for social communication still stands. The asylum was a site of information exchange, and not just for information pertinent to the management of the insane. As asylum superintendents benefited from gossiping with the chai wallahs, so other community members benefited from actively permeating the asylum.

Reading against the dominant voice in the asylum reports, we see the extent to which the British administrators were listening to their subordinate staff, be they wallah, keeper or warder. In 1869, Dr. Payne, the superintendent of Dullunda wrote that:

¹⁷⁶ As the previous chapter shows, related sciences, such as phrenology and social evolutionary theory, were discussed by intellectuals on both sides of the colonial interaction.

Babu Nibaran Chandra Banerjee is well-qualified in his task of cooking the daily meal, which the lunatics gladly receive each day in the courtyard. Old Babu has often suggested we reduce the quantity of spices we provide our lunatics, leading as it does to violence and intractable danger for the others and in the town... Babu's suggestion is both less expensive and, it seems, efficient in reducing the maniacal nature inherent to the lower castes... We no longer purchase the pagli¹⁷⁷ spice, much to the dissatisfaction of our peons, who regularly used it to flavour their foodstuffs.¹⁷⁸

Old Babu's recommendation to reduce the spiciness of the food demonstrates his personal belief that spice itself caused insanity. Although Western medical thought included a consideration of diet in promoting good health, by the mid-nineteenth century such 'humoral theory' was regularly overlooked in favour of the growing medical interest in contagion, degeneration and Mesmerism. While we do not have demographic data for Old Babu, it is certain he was not a student of Western medical theory. His ideas for reducing the spiciness of asylum meals would have been novel to the asylum superintendent who would have relied on Old Babu to make recommendations, due to the highly-ritualized way many believed Indian food had to be cooked (e.g. by caste). Moreover, Old Babu's recommendations were at odds with some of the other Indian staff: the peons, whom Payne mentions at the end of his letter, were upset at the reduction of spiciness in asylum meals. As such, we see three ideas of asylum management present in Payne's letter: Old Babu's, the peons' and Dr. Payne's.

In effect, with European and government employees being exposed to so many local and 'indigenous' ideas in the asylum, we can begin to see a hybridized form of asylum management developing. This hybrid system challenged the assumed dominance

¹⁷⁷ *Pagli* is a feminized Bengali adjective for 'mad' or 'insane'.

¹⁷⁸ Dr. F. Payne, *Annual Commentary on Bhowanipore, a Lunatic Asylum in Bengal* (Calcutta: 1869), BL. Old Babu was not a real name but a nickname, or *dak-naam*. It is likely that the staff first started calling him Babu, before the patients did too and then the British staff themselves.

of Western knowledge in the colonies. The actors who contributed to this new kind of knowledge were not stagnant within the asylum – they moved beyond the building, transporting and communicating knowledge across its walls, making the asylum very much a part of the fabric of every day life in colonial India.

The *Anandabazaar patrika*, a Bengali language newspaper, reported a riot that broke out in the local market near Dullunda in 1869, soon after the asylum had stopped purchasing large quantities of spices from the local bazaar. One group of vendors insisted that, borrowing from Hindu law, the British authorities should intervene and buy up the excess spices that the vendors had been unable to sell.¹⁷⁹ Dr. Payne's decision to follow Old Babu's advice had an impact on the community at large. The spice vendors in the market had relied upon the asylum's custom to make significant profit, but Old Babu's suggestion had cost these vendors this profit. They were also enraged that the asylum's association between lunacy and spicy food had carried beyond the asylum to affect the community's beliefs – this resulted in an even greater reduction in the vendors' sales of spices.¹⁸⁰

One of the consequences of this riot was the loss of employment by Old Babu's family. They were *paan* sellers in the local village,¹⁸¹ but Old Babu's recommendations had severely damaged the economic productivity of several of their peers and neighbours. With a general embargo placed on buying their *paan*, Old Babu's brother and nephew could no longer support the rest of the family. As a representative of colonial impartiality,

¹⁷⁹ *Anandabazaar Patrika*, 14 December 1869, BL.

¹⁸⁰ *Ibid.*

¹⁸¹ Their familiarity with the various spices used to make *paan* may be the reason that Old Babu held dietetic and spice-related ideas about lunacy.

Dr. Payne was asked to intervene by both Old Babu and the local spice vendors. We do not have a record of what was said, however Old Babu's family consequently began to work more closely with the asylum: his nephew found employment as a janitor, and his father worked alongside Old Babu in the kitchens.¹⁸² Dr. Payne, under the legacy of the *Arthashastra*, had been asked to intervene as a representative of the ruling class. The asylum was both the impetus for conflict and the location of a solution in this example. Conflicts beyond the asylum walls were able to penetrate the institution, and thus the asylum became appropriated within local Bengali politics.

As this story shows, local communities in Bengal often entered and interacted with the inhabitants of British-built native asylums; this behaviour was in contrast to the highly isolated and self-contained ways in which public asylums operated in Europe. The asylum was not an impenetrable monolith of colonial conquest but a space that was appropriated by the local community. It was not simply a place of therapy, but a space for employment, trade, socializing and – as I will now show – literal asylum.

Refuge and Kinship

The 'native' lunatic asylum was sometimes a place of refuge. Patna Asylum, built in 1863 along the banks of the river Ganges, was a public asylum funded entirely by the state and donations from charitable groups such as missionaries. The building was built entirely to the specifications of a Civil Surgeon, R.F. Hutchinson, whose detailed reports of the sanitary conditions, the location of windows and ventilation, and inmates' daily

¹⁸² Correspondence, V/28/1870, BL.

occupations provide rich insight into the every day events of a typical Bengal asylum.¹⁸³ Hutchinson seems to have borrowed heavily from the Kirkbride Plan, which was a system of lunatic asylum design advocated by Thomas Kirkbride, an American psychiatrist, earlier in the century.¹⁸⁴ Kirkbride's asylum design was itself based on a philosophy of 'moral treatment,' and a typical Kirkbride asylum had long 'wings' so that each patient had comfort and privacy, but also sunlight and fresh air. The grand appearance of the building was meant to have a curative effect on the patients, who were believed to internalize the pleasance of their surroundings – this was an idea to which Hutchinson also subscribed. On account of its beautiful appearance, however, Hutchinson's asylum in Patna received an inordinate number of requests for admission, and it expanded each decade with a new wing or set of buildings, until it looked quite different from Hutchinson's original plan.¹⁸⁵

During a particularly heavy storm in 1880, low-lying areas of Patna became flooded. Huge walls of mud moved along the Ganges and covered much of the town. For safety and shelter, most of the residents in the local village moved into Patna Asylum, which was relatively safe and stable on account of its constant maintenance and sturdier foundations. Overnight, the lunatic asylum became a literal asylum: a place of refuge. Once it became clear that the damage to the village could not be repaired immediately, the residents made more permanent dwellings inside the asylum. The central courtyard, where patients had been encouraged to run and maintain physical exercise, became the

¹⁸³ "Patna," *General Report on the Lunatic Asylums of the Bengal Presidency 1864* (Calcutta, 1865), 8, NAI.

¹⁸⁴ *Ibid.*, 10-13.

¹⁸⁵ *General Report on the Lunatic Asylums of the Bengal Presidency 1881* (Calcutta, 1882), NAI.

central bazaar. Families took to staying in particular wards or dormitories according to various village-based hierarchies; gurus and religious leaders utilized the already divided kitchen to prepare their food; the bureaucratic spaces, such as the superintendent's office, became the locus of village meetings, and even the British staff quarters – limited as they were – were appropriate by various village elders or those who required more comfortable sleeping space. Despite all of the chaos, the assistant superintendent of the asylum, W.D. Stewart, found himself “quite enjoying the interruption,” and there was a spontaneous musical skit that was performed that evening: “We joined in the dance and song, and applauded the performance of each artist with enthusiasm... insane and sane alike called upon their fellows to join... There never was any accident, but all behaved admirably and were very well pleased.”¹⁸⁶

Once the damage to the town had been somewhat repaired, the residents moved back to their homes, however the permeability of the asylum had been rendered more permanently than anyone could have predicted. We can glean such information from the vernacular press: Lord Lytton had enacted the Vernacular Press Act two years prior to Patna's flood, and summaries of local newspapers were kept as a result. While some saw this act as an effort to control local media and prevent criticism of British rule, others saw it as a progressive move that encouraged local debate.¹⁸⁷ For example, we learn that the assistant superintendent “often visits to play *teen pakaad*” with his new friends in the

¹⁸⁶ In his report, Stewart also wrote how, “for some days after the nautch, [we] endeavoured to set up an amateur performance, and amuse [ourselves] with cymbals, guitars and other native instruments after hours.” *General Report on the Lunatic Asylums, Vaccination and Dispensaries in the Bengal Presidency 1884*, compiled by Surgeon-Major J.T.C. Ross, Indian Medical Department (Calcutta, 1886), BL.

¹⁸⁷ For an example of the former, see M. Javaid Akhtar et al., “The Role of Vernacular Press in Subcontinent During the British Rule: A Study of Perceptions,” *Pakistan Journal of Social Sciences* 30, 1 (September 2010): 71-84. For a less critical view, see J. Natarajan, *History of Indian Journalism* (Delhi: Govt. of India Publishing, 2000), 100-112.

village;¹⁸⁸ the staff found it much easier to buy supplies and haggle prices in the local market;¹⁸⁹ and when one of the secretaries fell ill, first an Ayurvedic practitioner from the village came to visit, before a British medical officer could be called to treat him.¹⁹⁰ With the local community permeating the asylum walls, the Patna flooding allowed a conviviality between asylum and village that had nothing to do with treating patients or culturally-specific notions of insanity.

All asylum communities did not share this level of conviviality. However, superintendents and British staff often exhibited concern for the asylum and concern for the asylum community in parallel. This was especially true with regards to the families who visited the asylums regularly. Families were important as real actors who entered the asylum, but they were also important in how they influenced asylum discourse amongst other actors. As the private sphere of the family expanded to include the asylum, a somewhat domesticated organization of lunacy came into existence, which complicates modern scholars understanding of kinship in this period.¹⁹¹ This was especially important in the first three decades after the Lunacy Acts, when the asylum superintendents did not have families of their own in residence in India.

¹⁸⁸ This seems to have been a card game. “Prabat Kaabar”, *Vernacular Newspapers Report* (November 1880), 136, NAI.

¹⁸⁹ “We have been able to purchase [...] rice and dhal much more cheaply [...]. The doctor has shown remarkable talent at jhanjata [...]”. *General Report on the Lunatic Asylums of the Bengal Presidency 1881* (Calcutta 1882), 3, NAI.

¹⁹⁰ *General Report on the Lunatic Asylums of the Bengal Presidency 1882* (Calcutta 1883), NAI.

¹⁹¹ Historical anthropologists have built on the chequered relationship between history and anthropology to examine the meanings of caste and kinship in this time period. These hybrid works are useful in reevaluating the interaction between family, asylum and community within the routine opposition of ‘tradition’ and ‘modernity’ in India. Saloni Mathur, “History and Anthropology in South Asia: Rethinking the Archive,” *Annual Review of Anthropology* 29 (2000): 29–46. See also, Saurabh Dube, “Historical Anthropology of Modern India,” *History Compass* 5 (2007): 763–779.

Wallahs and families were active in the asylum, which encouraged the British asylum staff to become more active and affable with their local communities. The next section will show how the ecology of the asylum allows us to examine and include other kinds of historical actor in our analyses, beyond the physical site of the colonial institution.

Beyond the Walls

While we may acknowledge the contributions to the asylum community of those actors working on the ground more readily, it is important to realize their machinations are not entirely separate from the colonial machinations of the administration. We can stretch the metaphor of the ecological asylum community into administrative offices and groups of people far removed from the architecture of the asylum. The movements and correspondence between asylum communities demonstrates the existence of a group of actors involved in the management of the asylum, who existed beyond the walls of these institutions. Most of this sub-official realm was constituted by secretaries, who drafted and sent the official telegrams that authorized patient transfers.

The most common message at the official and sub-official level was one requesting transfer of asylum inmates and attendants, either at their behest, that of their relatives, or under local official orders. A brief tally of such requests within the National Archives of India shows up to 100 different individual ‘alleged lunatics’ being moved (voluntarily or involuntarily) every year of the 1880s,¹⁹² and over 200 attendants moving

¹⁹² See, for example, the tables at the end of the *Annual Report of Lunatic Asylums in the Bombay Presidency*, 1880-1889, NAI.

between asylums across this decade.¹⁹³ The asylum community was not simply constituted of people moving at a very local and proximal level; men and women were transported across huge distances, rendering the spaces between asylums part of the conceptual territory of the asylum. It is difficult to track the movement of such historically peripheral characters, but the ecology of the asylum does allow us to comprehend the great volume of men and women who constituted British India, beyond the urban records of cities, towns and institutions.

Why might asylum patients be transferred? Lack of space in increasingly crowded and dilapidated buildings was the most common reason. One sub-official message mentions the ‘capture’ of an escaped ‘lunatic’, by the name of Manraj, in Burma, and the need to return him to Bombay, to an asylum where his family could visit and care for him.¹⁹⁴ The notion of the Indian family and the importance of kinship were highly respected by the colonial government.¹⁹⁵ As such, the administrators who corresponded regarding Manraj, often sub-officially, were very keen to return him to his home in Bombay. The popular belief that lunacy was exacerbated by being in an unfamiliar environment was corroborated by the medical expertise (of British and local men) sought by these administrators.¹⁹⁶ Despite their best efforts, however, the sub-official network

¹⁹³ *Suggestions and instructions regarding the construction of Native Asylums*, Home Department, Medical B, January 1891, Nos. 92-98, NAI.

¹⁹⁴ Letter no. 124, 11 March 1884, “Requesting the Removal of an alleged lunatic named Manraj from Burma to Bombay”, Home Department, Medical A, April 1884, Nos. 124-125, NAI.

¹⁹⁵ Gauri Viswanathan has written extensively about kinship in India, from a historical anthropology perspective. See *Masks of Conquest: Literary Study and British Rule in India* (Oxford: Oxford University Press, 1998).

¹⁹⁶ British officials outside the immediate purveyance of the asylum read such texts as Henry Maudsley’s *Natural Causes and Supernatural Seemings* (London: K. Paul, Trench & Co., 1886), and William James Moore’s *A Manual of Family Medicine and Hygiene for India* (London: J. & A. Churchill, 1883), both of which suggested that lunacy had environmental as well as hereditary causes.

were unable to secure adequate transport from Burma, and the man died of natural causes three months after his request was first made.

This story adds another set of actors to think about: the transporting staff. Sometimes asylum patients were transferred using government vehicles but a more economical choice, which was employed more often, was to request traders, or local men who traveled regularly and owned transport, to move them. In the case of Manraj, above, several administrators in the Medical Department sought the help of sailors and naval captains to transport him from Burma to the port of Calcutta and, from there, eastwards to Bombay. One such sub-official telegram writes:

As it is not possible to obtain a passage for Manraj on an ordinary steamer, and his further detention in this country is likely to prejudice his chances of recovery, we may ask the Army Department whether a passage in a troopship can be arranged for him. Might it be possible to allot a passage for the patient either in the *Rewa* or the *Dongola*, which leave Burma on the 6th and 20th of next month?¹⁹⁷

The telegram invokes both the Army Department and the already rejected connection with “ordinary steamers” and their captains. The sources do not tell us why Manraj could not be transported in this manner, but the subsequent responses of the Army Medical Board secretary tells us that transport via troopship was considered carefully.¹⁹⁸ Sadly, Manraj died before he was able to transfer home to Bombay, either because communication for his transport took so long or due to physical ailment. Despite the asylum being a permeable space, across such long distances the patients were still subject to the whims of their government.

¹⁹⁷ Letter no. 525, 20 August 1884, “Removal to Bombay of Manraj, an escaped lunatic”, Home Department, Medical B, October 1884, 73-85, NAI.

¹⁹⁸ There is a note, the author of which is unknown, written by hand on the telegraph, describing how passage to Bombay via Calcutta can be arranged.

It was normal for so many letters to be written regarding such a specific issue. In 1893, Chief Commissioners of Burma, Assam and the Central Provinces, and Secretaries to the Governments of Madras, Bombay, Bengal, the North-western Provinces and Oudh all wrote, at the behest of the Superintendent of the lunatic asylum at Delhi, to ask that the privileges received by hospital assistants and jail warders be given to “warders of lunatic asylums” under article 320 of the Civil Service Regulations.¹⁹⁹ The article permitted jail warders and others “while ill in hospital or dispensary or receiving medical aid as out-door patients of the hospitals or dispensary of the station [...] half-pay for certain periods.”²⁰⁰ Privileges were extended, and another round of correspondence was distributed to confirm the change.

Burma is an excellent locus to analyse the administrative elements of the asylum community, who existed beyond the physical institution, and corresponded daily with other administrators from other departments. In December 1870, as a result of a survey that found Burmese lunatics to be lacking in therapeutic institution,²⁰¹ the Chief Commissioner of British Burma and the Secretary to the Government of India both communicated the establishment of a lunatic asylum at Rangoon. This marked the end of almost a year of correspondence between a variety of subordinate secretaries in the

¹⁹⁹ Letters for the extension of the provision of Article 320 of the Civil Service Regulations to Warders of the Lunatic Asylums, Home Department, Medical, September 1893, Nos. 14-21; Article 320 of the Civil Service Regulations, Resolution No. 661-672/6 Jails, dated 7th November 1891, NAI.

²⁰⁰ Proceedings of the Government of India in the Home Department (Medical), Simla, 9th September 1893, 21, NAI.

²⁰¹ The 1868 asylums survey will be discussed in the next chapter. It was not a catalyst for asylum reform in general, but it revealed a dearth of asylum facilities in some parts of the subcontinent, such as in British Burma.

Government of India and in the local government of Burma. The need was articulated thus:

It is an institution which in the interests of humanity is very much needed, and the removal of our insane population from the Criminal Jails to a special Asylum will be felt as a boon by all classes of people. The Chief Commissioner therefore trusts that the present application will meet with the favourable consideration of His Excellency, and he solicits that he may be favoured with a reply as early a date as possible.²⁰²

The opinions of the Inspector General of Prisons and the Sanitary Commissioner were also invoked, via their secretaries and subordinate officers. The Inspector General of Prisons in Burma was eager to “introduce a large convict element into the constitution of the establishment”, garnering employment of his staff as “more trustworthy, much more intelligent and much more orderly than any whom it is possible to find amongst the class of free natives of India which alone would be disposed to take service in the institutions”.²⁰³ The department of the Sanitary Commission penned several notes to “Surgeon-Major Payne, who has so long had the superintendence of both the European and Native Asylums here”²⁰⁴, to garner the opinion of the Dullunda and Bhowanipore asylum administrators for the number of staff required to successfully run a lunatic asylum in Burma:

For so small an institution, a matron is unnecessary, as with the aid of native women servants, the female lunatics can be overlooked by a Deputy Overseer

²⁰² Letter No. 152, 10th December 1870, from Captain Malcolm Furlong, Assistant Secretary to the Chief Commissioner of British Burmah, to E.C. Bayley, Esq., CSI, Secretary to the Government of India. Home Department, Public A, April 1871, Nos. 38-39, NAI.

²⁰³ Letter of 28th September 1870, from the office of the Inspector General of Prisons, British Burmah [sic]. Home Department, Public A, April 1871, Nos. 38-39, NAI.

²⁰⁴ Surgeon-Major Arthur Payne was the long-serving Superintendent of Dullunda and Bhowanipore Lunatic Asylums in Bengal. Letter No. 38, 8th April 1871, from the office of J.W.M. Cunningham, Esquire, Sanitary Commissioner with the Government of India, to E.C. Bayley, Esquire, CSI, Secretary to the Government of India. Home Department, Public A, April 1871, Nos. 38-39, NAI.

[...] A Native Doctor on Rupees 25 would be sufficient in place of a Hospital Assistant on Rupees 50.

Cooks, sweepers and bhisties may be convicts without any disadvantage, but for personal attendance on the lunatics they will not, I fear, answer well. The work is of an exceptional kind, requiring special training, and it is therefore desirable that [...] the keepers should not be convicts but paid servants.²⁰⁵

In this section, we see the ‘sub-official’ colonial administration at work alongside the physical community of the asylum at specific sites. Reading the official documentation alongside the vernacular press and unofficial correspondence thus gives us much more than simply richer historical detail; it constructs a much larger notion of community. Alongside the doctors, the patients, the asylum attendants and the actors ‘on the ground’, we also find a network of administrators, visiting missionaries, and existing princes and sovereigns with their own jurisdictions. We can conceptualize this community, then, as the extension outwards of the physical landscape of the asylum, or we can imagine this community as the permeation of local people into colonial spaces. In some ways, we can think of the correspondence and movements of wallahs and attendants across asylums as doing the same work of wallahs, dhobis and locals earlier in the chapter, on a macrocosmic scale. By circulating both people and ideas about asylum management, asylums were connected in a dynamic community, permeated by a variety of actors.

In many ways, these asylums were a means for the Government of India to know the native – but not in a Foucauldian sense. Inspector General O’Callaghan, of Lucknow, and Dr. Payne, of Calcutta, were not enumerating and disciplining native minds. They developed a rapport with their patients, the visiting families and the local communities.

²⁰⁵ Correspondence, W.M.S., 1-12-70, to J.M.C., Home Department, Public A, April 1871, NAI.

They knew the natives in the same way that the natives knew them: informally, domestically, for work and through relaxed socializing. The increasingly permeable walls of the asylum permitted the greater community to use the asylum almost seamlessly in conjunction with their own communal and public spaces. This space was officially the property of the British government, but in practice, colonial representatives and colonized subjects had the same access to it; in fact, some members of the community, like the *chai wallahs*, had greater authority over this space than the British staff.

This chapter has shown that, at each site, an asylum community existed, functioning only tenuously within the confines of the colonial structures above it. Each institution exhibited a degree of permeability across the asylum walls, where local and imperial knowledge interacted. The notion of ‘community’ both as a physical description of the people living and working around the asylum, and also ecologically to describe the entire asylum system, helps us to construct a history of these spaces that constituted madness, on the ground and within the colonial administration. The actors who constitute the asylum community cover a wider spectrum than might initially be assumed. In the next chapter, I show how the permeability of the asylum is reflected in the superintendents’ management of their institutions.

Chapter 3: A Decade Later: The Survey and the Superintendents

In the 1860s, the Home Department sent out a survey to the superintendents of all the lunatic asylums under the jurisdiction of the Government of India, from Bareilly and Benares in the North-western Provinces, to Rangoon in British Burma. Fifteen men responded, but only thirteen of them oversaw existing institutions. W. P. Kelly, the Inspector General of Prisons in British Burma, and John Graham Cordery, the First Assistant Resident in Hyderabad, wrote to inform the Government that there were no asylums in their territories. The government officials in the Home Department were unclear as to how many lunatic asylums they had established in India; one goal of the survey was to ascertain this, as well as, by extension, the number of ‘insanes’ in the subcontinent. The survey extended to “European” institutions as well as “native” ones. Each asylum superintendent’s responses were recorded and published as an official document entitled “Care and Treatment of Lunatics in India” in 1868. Simple in form and execution, the 1868 survey is illustrative of the first significant intervention after the 1858 lunacy legislation by the government.

The results were not comprehensive. Superintendents responded to the survey questions in varying degrees: some were very detailed in their answers, while others only provided the bare minimum information. As an archived collection of documents, the survey provides the modern historian with a remarkably detailed window into India’s network of lunatic asylums, from the names and locations of each institution to the size of each patient’s bed and the quantity of rice he or she ate each day. When compared with the Annual Asylum Reports (which were collected and published by the Government’s Home Department each year), the survey responses show greater variability in terms of

the kinds of patient treatment and care at each asylum. The survey gave superintendents the opportunity to reinforce prevailing stereotypes about their local communities, but their answers also display nuance in reflecting the idiosyncrasies inherent to the asylum under their charge. In contrast, the Annual Reports make for more prosaic reading, reflecting as wearied an attitude to the everyday asylum experience as the superintendents may have felt in completing the Reports each year. Why did the Government of India require extraneous information on top of what was required in each asylum's Annual Report? Why was a separate form, a different set of questions, distributed if the Annual Reports continued to be collected throughout the 1860s? Why ask novel questions of the already-surveyed institutions?

Superintendents in the asylums came from a variety of different backgrounds. Recruited by the British Raj to oversee a novel colonial institution, their training was not specific to asylum management. This was in stark contrast to their peers in Britain, who considered and debated asylum management quite passionately in journals and letters. Asylum superintendents in the British Raj were overseers: their training was administrative, and their aspirations were not always specific to medicine. On paper, at least, some of these officers saw the jail, the medical hospital, the lunatic asylum and the military barracks as interchangeable.

This chapter examines the 1868 intervention in two ways: the first comprises the genealogy of the survey, with its relationship to the development of the Indian census and, specifically, the British motivation to understand and categorize Indian religions and castes; the second speaks to the permeability and local variability of each asylum, as manifested through each asylum superintendent's voice. The superintendents represent a

group of actors who are central to this chapter; each section of the survey is replete with details of their motivations and specific as well as subordinate agendas. Their voices are also central to locating the growing tension between the Government of India's medical and judicial branches, which both maintained authority over the asylums.²⁰⁶

The asylum survey's title initially presents some confusion: designated "Care and treatment of lunatics in India", it focuses more on the asylum superintendents and their institutions than it does of the lunatics therein, and the list of participating asylums seem to come from only Bengal. Upon reflection, this is confusing only under the rubric of contemporary boundaries and values. In actuality, the Bengal Presidency was a much larger area than the modern states of West Bengal and Bangladesh, and the Government of India consistently privileged developments in Bengal as representative of developments in the Indian subcontinent.²⁰⁷ Moreover, the superintendents and the buildings under their charge necessarily constituted the entirety of the care and treatment they could provide for lunatics in the subcontinent, because the Government had little else with which to assess and treat its insane. Ensuring there was a physical space to care for lunatics and a British officer act as its superintendent were knowable and viable goals for the newly minted government, who surveyed their asylums under familiar tropes of insanity and of colonial institutions instead of drawing upon novel theories and practices emerging from a psychiatric science that had not yet assimilated into mainstream medicine in England.

²⁰⁶ The tension between medical and judicial branches will be discussed in greater detail in the next chapter.

²⁰⁷ This privileging occurred in spite of the vast array of ethnographic data they collected, which showed how different Bengal was from other parts of India, and how different were communities across Bengal. Such steadfast beliefs in Bengal-as-representative unfortunately carried over into much of the historical work done in the 1960s and 70s, until the subaltern turn radically changed the way scholars viewed South Asia and its history.

To answer the survey questions, the British officers who were appointed as asylum superintendents had to interact with their institutions in a different way from their usual routine for completing the Annual Reports. They had to extend the process of information gathering to their staff, which included native attendants as well as British personnel. Bernard Cohn has described how the Indians who made the nineteenth-century Indian censuses possible were “a highly significant group, as they were literate and educated, even if only at a primary school level”²⁰⁸. This is also true of the asylum’s native attendants, for whom the survey was a direct effort to know their roles within the colonial asylum, as well as the patients they treated. Gathering information, and using native sources or informants, will be discussed later in this chapter; for now it is worth noting that the survey was related to other attempts to gather data in the colony, such as the Indian “Gazettes” and the provincial and all-India censuses.

My examination of the asylum survey borrows from the critical analyses performed by historians of the Indian census in the 1980s and early 1990s. Social historian Kenneth Jones wrote that British-Indian census reports could be utilized as the subjects of research themselves, rather than just a useful source of data. Such a source:

[...] is most correct when that which it counts exists in a clearly defined state, but relatively little in life is clearly defined or placed in pre-determined categories. Those who would take a census then are first faced with the task of creating categories... Categories necessitate definition and definitions impose order. What it means to be a child, a Hindu, to speak a particular language, belong to a specific social class, or follow a given occupation, will be formally defined in a way which did not exist prior to the creation of the census. Thus from its very beginning a census acts to reshape the world it will examine.²⁰⁹

²⁰⁸ Bernard Cohn, *An Anthropologist*, 248.

²⁰⁹ Kenneth Jones, “Religious Identity and the Indian Census,” in *The Census in British India: New Perspectives*, ed. N. Gerald Barrier (New Delhi: Manohar, 1981), 74.

In other words, censuses and surveys were not passive records of data, but provided catalysts for change, either by redefining the world around them or causing their subjects to reflect and react to the questions being asked. In asking questions about the degree or diagnosis of insanity, the survey suggested and prioritized categories of madness to the superintendents who were thereafter predisposed to use them.

Chris Bayly has been quite dismissive of some modern historians for depicting the Indian census as “a ‘hegemonic’ exercise, enabling Britons to divide and enfeeble the peoples of the subcontinent by subjecting them to a demeaning and destructive process of ‘essentialisation’”.²¹⁰ For example, in an otherwise perceptive article, Waltraud Ernst wrote that “the emphasis on statistics and questions of medical nomenclature”, as seen in the 1868 asylum survey, could be regarded as “related to narrowly medicalized concerns, but also as part and parcel of the controlling and hegemonic strategy of colonialism.” She went on to suggest that “data collection and the controlling strategies of nomenclature and classification lend themselves to being water-carriers of any discourse of power.”²¹¹ I do not pretend that the asylum survey was without Foucauldian tropes of power/knowledge, not least because the increasingly powerful and intrusive colonial regime that was established after 1857 used the uprisings as a reason to count, classify and control the subcontinent’s people in many other institutions. However, the survey offers just as much historical value as a window into the everyday life of the native asylum, especially the asylum superintendent’s concerns at each site.

²¹⁰ Chris A. Bayly, “Western ‘Orientalists’ and the Colonial Perception of Caste”, in *Caste, Society and Politics in India from the eighteenth century to the modern age*, ed. Susan Bayly (Cambridge; New York: Cambridge University Press, 1999), 98.

²¹¹ Waltraud Ernst, “Crossing the Boundaries of ‘Colonial Psychiatry.’ Reflections on the Development of Psychiatry in British India, c. 1870-1940.” *Culture, Medicine and Psychiatry* 35 (4): 543.

Nicholas Dirks is another historian who challenges a simple Foucauldian reading of knowledge/power in nineteenth-century Indian surveys. He rejects that the object of study in India was simply a ‘society’ of individuals who were controlled through “small techniques of notation, of registration, of constituting files, or arranging facts in columns and tables”²¹², and argues that it was much more than this: the Government wanted to discover and know “an alien world of ‘communities’ and ‘cultures’”, and “to know these, local information and local subjects were critical.”²¹³ From a Dirksian perspective, the asylum survey was not fixated on controlling and knowing individuals (neither the superintendents nor the patients provided the focus of study), but was concerned with ascertaining the system in which the asylum functioned, examining a birds-eye view of the communities that interacted at these sites, and the heterogeneity of these interactions. Both the Annual Reports and the 1868 survey provided information about the individuals and the communities who inhabited the asylum; while some of the categories precluded other ways of knowing (caste, for example, was a favourite grouping), these forms of data collection also represented a genuine desire to “discover”, rather than simply “know”.

Yet another imperial historian, David Gilmartin, has reiterated the idea that hegemony, power and control were the only facets of data and documentation in British India:

“The British ‘science of empire’, with its reliance on the systematic description and classification of Indian society, underlay the power of an increasingly bureaucratic state that mobilized indigenous communities in support of the

²¹² Michel Foucault, *Discipline and Punish: the Birth of the Prison*, trans. A. Sheridan (New York: Pantheon Books, 1977), 190.

²¹³ Nicholas Dirks, “Castes of Mind,” *Representations* 37 (Winter 1992): 57.

colonial order. By its very reliance on the scientific processing and ordering of local knowledge, it defined a critical place within the structure of power for local people (i.e., those whose power was rooted in local relationships and particularistic idioms). State concerns with ‘discipline’ and ‘control’ were certainly not lacking, but to the degree that the object of social scientific knowledge in India was both the individual and the ‘cultures’ and ‘communities’ of India, the discourse of ‘scientific’ administration was one in which powerful Indians were joined.”²¹⁴

Both Dirks and Gilmartin lean towards a similar argument. Knowledge of British India was not simply a powerful tool of governance. By the same token, many ‘natives’ were not simply passive recipients of its governance, and were *complicit* in the process of surveying and collecting data about India. In delegating the task of information collection to local Indians in the pan-India censuses and in the native asylums, one could make the argument that the British government was exploiting their colonized subjects in order to know and discipline them under the colonial regime. However, if we see these data collectors as active participants, we can also make the argument that their intentions were complicit with their colonizers, at least at a local level. They, too, were eager to discover how the asylum functioned, how their communities were used or employed, and were even curious as to the amount with which their neighbours were enumerated in their employment. Rather than assuming these men and women were passive subjects, we can ascribe to them a degree of agency that allows them to be actively involved in the task they were given, and to shape the data and knowledge they collected.²¹⁵

Helen Tilley has assessed the African Research Survey (1929-1938) with similar research goals in mind. Tilley considers how the Survey gave impetus to British

²¹⁴ David Gilmartin, “Scientific Empire and Imperial Science: Colonialism and Irrigation Technology in the Indus Basin,” *The Journal of Asian Studies* 53, 4 (November 1994): 1130.

²¹⁵ This was rather like the survey and the censuses themselves, which were conduits for British attempts to document and know the native and worked to shape the form of data that was received.

development schemes until decolonization later in the twentieth century. She notes that the people engaged in creating and maintaining structures of imperial dominance in Africa were the same people who questioned Europe's right to colonization, its epistemic authority and norms.²¹⁶ Like her, I am interested in the interlocutors of the survey: both the asylum superintendents and the staff working under them. In this way, I hope to show how native these superintendents were, being entirely unsupported by their own administration at this point and steeped in local everyday life.

Starting with a discussion of the ways in which we can understand complicity and agency in this chapter, I will briefly examine the history of the Indian census and, by extension, the asylum survey of 1868. In doing so, I hope to demonstrate how religion and caste came to be key categories in defining and surveying the Indian asylum population. I will also suggest that the Foucauldian mantle of collecting knowledge as a form of power be rethought in the context of the native lunatic asylum; recognising that the science of psychiatry and the mode of colonial governance were themselves inchoate in the 1860s, I submit that surveying the existing network of asylums was an opportunity for discovery and experimentation, as well as data collection, management and knowledge production. This chapter will present the most illustrative responses to each section of the survey, along with pertinent biographical contexts for the superintendents who voiced these responses in each institution. The evidence points to extraordinary variability across the native asylum network, and the absence of a coherent doctrine of asylum care suggests a massive administrative failing on the part of the British government. We can only appreciate the significance of this administrative failure by

²¹⁶ Helen Tilley, *Africa as a Living Laboratory: Empire, Development and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011), 320-335.

combining a micro-historical examination of each asylum, via the superintendents' survey responses, with an overview of the still-nascent Crown rule of India. The chapter concludes with an argument for the genealogy of the survey being representative of a genealogy of colonial institutions and of the increasing tension between the legal and medical branches of the British government.

Complicity, Agency and Informants

Too often, academic literature defines 'complicity' in the legal and accusatory sense of "being involved with others in an illegal activity or wrongdoing".²¹⁷ Legal scholars refer to this as the "doctrine of complicity", which determines whether a person is liable for a crime committed by another.²¹⁸ This meaning is the most commonly used definition in the by social sciences and in history alike. Ranajit Guha describes the Indian National Congress as being *complicit* in maintaining those forms of feudal oppression that permitted and perpetuated British rule even as the INC aimed to remove the shackles of colonialism and apply its nationalistic goals.²¹⁹ Sociologists such as Minoo Moallem admonish both egalitarian feminism and religious fundamentalism for their *complicity* with the very modernity that they claim hegemonizes people under the same universalist rubric, not allowing for geopolitical and cultural difference.²²⁰ In fact, some scholars

²¹⁷ "Complicity," in *Oxford Dictionary of English*, ed. Angus Stevenson (Oxford; New York: Oxford University Press, 2010).

²¹⁸ Sanford H. Kadish, "Complicity, Cause and Blame: A Study in the Interpretation of Doctrine", *California Law Review* 73, 2 (March 1985): 323-410.

²¹⁹ Ranajit Guha, *Dominance without Hegemony: History and Power in Colonial India* (Cambridge: Harvard University Press, 1997), 132.

²²⁰ Minoo Moallem, "Transnationalism, feminism and fundamentalism", in *Globalization: Critical concepts in sociology*, eds. Roland Robertson and Kathleen E. White, pp. 191-218 (London: Routledge, 2003), 198.

posit complicity as an idea that is mutually exclusive to and always in opposition with agency, which is associated with resistance (to sexism, to colonialism, etc.).

Reading the survey with this notion of complicity would obscure the actual number of actors who were involved with its execution. I argue that such a binary – complicit *or* agential – is too simple. A simple theorization of everyday power relations would suggest these are both apparatuses of power: agency represents a mode of action where general economies of domination and the discursive limits of a regime constitute the agent, and complicity can act to dominate Others by homogenizing the actions of many into one outcome.²²¹ The asylum survey was compiled by a British physician, and executed by the Home Department of the Government of India; these men can be said to have agency, and also to be complicit with the desires and etiquette demanded of their roles within the British administration. The medical officers and asylum superintendents who received the survey were entirely complicit with the orders from their superiors, but demonstrated independence by responding in inconsistent and idiosyncratic ways; for example, some officers did not respond at all, and others, with no native lunatic asylum under their jurisdiction, furnished the report with as many details as they could find.

Philosopher Michael Bratman has contemplated complicity in terms of accountability and ‘shared agency’ or ‘coordinated concatenation’. There are two elements to this complicity: a moral or legal accountability that bonds each party of the coordinated effort (which is the element most often prioritized in discussions of complicity), and a “more general phenomenon of acting together”. This latter element

²²¹ Joe Parker, “Questioning Appropriation: Agency and Complicity in a Transnational Feminist Location Politics”, *Journal of Feminist Scholarship* 3 (Fall 2012): 1-17. For more on Foucault’s theory of power relations, see Michel Foucault, “Two Lectures”, in *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977* (New York: Pantheon Books, 1980), 78-108.

involves a “distinctive way of thinking about one’s own activities as part of *our* activities”, which appeals to the intentions of each “complicit” participant, each with different agencies, and the inter-relations between those intentions.²²² Bratman’s intentional theory of complicity informs my reading of the asylum survey of 1868.

Locals were often involved in subverting or exploiting the supposedly scientific and rigid systems of knowledge that the British brought with them and established in India. In 1881, a community of “Mahtons” successfully petitioned to be recategorized in the Indian census as “Rajputs”, who had separated from the direct Rajputian lineage by becoming agriculturalists. The Punjab government had established a zamindari²²³ scholarship for Sikh and Hindu Rajputs, and the Mahtons wanted access to this. Not only was it beneficial to assume the social standing of Rajputian caste attributes, but also it was useful to give the appearance of complicity with the British government’s and their hierarchical organization of caste in order to gain monetary privileges.²²⁴ Under a Bratmanian notion of complicity, the Mahtons were as accountable to the propagation of a hierarchical caste system in India as their British rulers; however, they had different intentions, an agential enterprise quite separate from the British motivations for categorizing caste. These Mahtons subverted the British hierarchy of caste and complied with the hierarchy at the same time. Building on my previous chapter’s argument about the complexity of the attendants’ roles, this chapter will use the asylum survey to show

²²² Michael Bratman, “Complicity and Shared Agency”, Stanford Humanities Center, <http://humanexperience.stanford.edu/motivation-bratman> [accessed August 12, 2013]. For an extended discussion of agency, in all its philosophical guises, see *idem.*, “Introduction,” in *Structures of Agency: Essays* (Oxford: Oxford University Press, 2007), 4-12.

²²³ *Zamindar* roughly translates to “land-owner”. *Zamindari* is the adjectival form.

²²⁴ Deputy Commissioner Office Jullundur Census, ‘Classification of Mahotons in the Census’, English File 5/vii, 1911, BL.

how superintendents were agential and complicity at the same time. While there was little to be gained by playing up to colonial beliefs about insanity in the subcontinent, there were certainly opportunities for asylum superintendents to reflect and recycle the same rhetoric as the survey to suggest conformity to the psychiatric treatment of non-restraint, even if such ideas were not observed in practice.

The etymology of complicity is the fourteenth-century French *complice*, meaning “comrade” or “accomplice”, derived in turn from the Latin *complicare*, or “to fold together”. This folding together, the partnership between surveyors and superintendents, between government and informant, is the notion of complicity that I use in this chapter. To understand how the asylums survey became embroiled in the complicit-agential relationship I have outlined in this section, it is important to detail the history of its development. Contextualizing the survey will also shed light on the significance of the superintendents’ responses that follow.

From Census to Survey

There were numerous theories on how India might be governed: while some advocated a Platonic model of guardianship, and the evangelicals believed it was Britain’s preeminent mission to civilize and ‘Christianize’ the heathen, the utilitarians sought to introduce an efficient administration and encourage habits of scientific and rational thinking among the ‘superstitious’ people of the land. The so-called ‘romantics’ fought for the preservation of Indian customs and institutions, in the belief that any attempt to tamper with indigenous beliefs would be received with hostility. Common to all these schools of thought was the assumption that Britain’s mission was to rule, and it was India’s duty to submit. Having become their responsibility to govern India, the

British were compelled to acquaint themselves with the languages and knowledges used by Indians. These tasks assumed particular importance in the nineteenth century, as the Company gave way to the Crown, and the conquest of territories required numerous mechanisms that would enable the state to know, measure and count the subjects that were brought forward. It was not necessary to know every Indian, because the individual Indian did not exist: in the British conception of Indian society, only collectivities existed. It was only necessary to know every type of Indian.²²⁵

The 1868 asylums survey can be seen as a direct descendent of the British census, which was developed at the end of the eighteenth century and within a very different social and political milieu. In the middle of the eighteenth century, many European states believed their societies to be improving and aspiring towards a perfect modern civilization.²²⁶ Mr. Potter, a Member of British Parliament, showed concern over the extent of poverty and population decline (as well as the economic relief required to alleviate it) in 1753, submitting the first British bill for a national census. The bill was called “An Act for Taking and Registering an Annual Account of the Total Number of Marriages, Births, and Death; and also the total Number of Poor receiving Alms from every Parish and Extraparochial Place in Great Britain.”²²⁷ While this proposal was

²²⁵ Just as the fetish for numbers had overtaken England and Europe earlier in the nineteenth century, the colonial administrator, the anthropometrist and the anthropologist aspired to “collect full information regarding castes and occupations throughout British India,” in an ambitious project soon after the Rebellion of 1857-58. Sir John William Kaye et al., *The People of India: a series of photographic illustrations, with descriptive letterpress, of the races and tribes of Hindustan, originally prepared under the authority of the Government of India* (London: W.H. Allen and Co., 1862-1872).

²²⁶ Geoffrey Gilbert, introduction to *An Essay on the Principle of Population*, by Thomas R. Malthus (Oxford, 1798; rpt. 1964), viii.

²²⁷ D.V. Glass, *Numbering the People: The Eighteenth-Century Population Controversy and the Development of Census and Vital Statistics in Britain* (London: D.C. Heath, 1973), 11.

defeated, the anxiety over population decline and poverty, especially due to war or disease, continued to gather strength. Thomas Malthus' popular essay, *On the Principle of Population*, which was published at the dawn of the nineteenth century, pushed the House of Commons to pass "An Act for Taking Account of the Population of Great Britain and the Increase or Decrease thereof" on 3rd December 1800.²²⁸

The first British census was subsequently taken on 10th March 1801, and repeated every ten years thenceforth. It sought to gather numerical information about population decline or increase, and other demographic and economic factors, such as education levels and language. In 1807, the East India Company commissioned a study to gather similar information on the individuals and territory under its control, but the inchoate authority of the Company over the subcontinent precluded serious work on a census until later in the century.²²⁹ In the mean time, Company officials commissioned a number of related documents: topographical surveys, maps, and mid-century provincial censuses. The first local censuses were taken in the North-West Provinces in 1853 and in Punjab in 1855, with a view to conduct an India-wide census in 1861. While British censuses and surveys during this period were hesitant to make religious enquiries of the British population, the provincial Indian censuses and topographical surveys employed religion as one of their fundamental categories, the basis for both diagnosis and prognosis of communities, occupations and health.²³⁰ The only significant area of the censuses in

²²⁸ *Ibid.*, 18. In the same vein as some of the scholars mentioned in this chapter, Potter's colleagues defeated his bill in Parliament because they feared it was a potentially repressive measure.

²²⁹ Henry Scholberg, *The District Gazetteers of British India: A Bibliography* (Switzerland: Inter-Documentation Company, 1970), 2.

²³⁰ *Guides to Official Sources, No. 2, Census Reports of Great Britain, 1801-1931* (London: His Majesty's Stationery Office, 1951), 4-5. The last British census in India to enumerate caste was 1931, however the most recent Census of India (in 2011) marked a return to the old colonial system: at the behest of several

which a religious dimension was absent was the section that counted the number of deaf, dumb, blind, lepers, idiots and the insane.²³¹

The British obsession with religion in India had begun well before the advent of Crown rule, but it was only with the massive bureaucratic machinery that was created after 1858 that the government was able to produce sufficient regional and provincial ethnographic data to validate this obsession.²³² Chris Bayly would argue that the British fixation with Indian religious and caste systems stemmed from their first interactions with port city communities in the eighteenth century, especially the artisans and mobile commercial people who were able to charge higher prices for items that had particular religious or caste significance.²³³ Two key tropes emerged from these interactions: the ineradicable communal difference between Hindus and Muslims or non-Hindus, and a rigid commitment to Brahman-centered caste hierarchy.²³⁴ Preexisting stereotypes about Indian religions and castes carried with them generalizations about the emotional and mental predispositions – “the Hindoo is mild and timid, rather disposed to melancholy, and effeminate pleasures” – which were carried back to Britain in published reports.²³⁵ These published reports included district *Gazetteers*, the decennial all-India Census (from

ruling coalition leaders, and for the first time in 80 years, Indians were asked to categorise themselves by caste, as well as religion, race, language, etc. Whereas Indians exaggerated their caste status under the British Raj to gain social status, it is widely believed that many individuals downplayed their caste status in the 2011 census to benefit from the new social and political valence of membership in non-elite groups.

²³¹ Government of India, *Memorandum of the Census of British India of 1871-72* (London: George Edward Eyre and William Spottiswoode for her Majesty's Station Office, 1875), 5.

²³² Bayly, “Western ‘Orientalists’”, 99.

²³³ *Ibid.*, 105-108.

²³⁴ Ronald Inden has described this portrayal of Indian culture as the “imagined India”, filled with “false and dehumanizing orientalist stereotypes”. Inden, *Imagining India* (London: Hurst & Company, 2000), 5.

²³⁵ Bayly, “Western ‘Orientalists’”, 185.

1871 onwards), provincial statistical reports²³⁶, and encyclopaedic surveys²³⁷, all in an effort to enumerate the Indian populace in a centralized, ‘scientific’ and truly Victorian fashion.

If the British census was the first of its kind, the Indian census was its eldest son, being almost identical to its parent in form (arguably even the same printer set the pages) and the catalyst for similar censuses elsewhere in the Empire.²³⁸ By extension, the Indian census and the asylum survey were siblings. They were born in the same period: the 1861 census was deferred till 1871 by the disturbances of 1857-8, and the asylum survey was executed in 1868. The fact that both were the result of a foreign colonial power meant that, from the beginning, the Indian census and asylum survey were fundamentally different in content from the British reports, despite the Indian census form being identical to its British parent.²³⁹ The Indian census writers were interested in “historical,

²³⁶ For example, see Sir William W. Hunter’s twenty-volume *A Statistical account of Bengal* (London: Trübner & Co., 1875-77).

²³⁷ H.H. Risley’s four-volume ethnographic survey of Bengal, *The Tribes and Castes of Bengal* (Calcutta: Bengal Secretariat Press, 1891) contributed a large amount to the development of the 1901 census of India.

²³⁸ Jones, “Religious Identity”, 78. Censuses were also taken for the first time in 1871 in British Canada. As my first chapter shows, the Indian lunacy laws bore similarities with the British lunacy laws. Using British policies and institutions as the first draft of Indian policies and institutions was common practice in the British Raj. In practice, many of those similarities dissolved, as is demonstrated with the lunatic asylum between 1858 and 1912.

²³⁹ The census was borne out of the late C18 and C19 Indian reports, which were themselves modeled on the great encyclopaedic Mughal surveys, such as the *Ain-i-akbari*, or “Constitution of Akbar”. The latter was an enormous C16 document, containing administration reports, statistical compilations, and regulations for the judicial and executive departments of the imperial household. An article by the Royal Asiatic Society of Britain first brought out the importance of the *Ain-i-akbari* statistics in 1918, and it has received scholarly attention from economists and historians ever since. W.H. Moreland and A. Yusuf Ali, “Akbar’s Land-Revenue System as Described in the ‘Ain-i-Akbari’,” *The Journal of the Royal Asiatic Society of Great Britain and Ireland* (January 1918): 1-42. For more information on *Ain-i-akbari* in economic history, see Shireen Moosvi, “Production, Consumption and Population in Akbar’s Time”, *Indian Economic Social History Review* 10 (1973): 181-195. For context, see R.C. Majumdar, *The Mughul Empire* (Mumbai: Bharatiya Vidya Bhavan, 2007), 90-109.

archaeological, political, economic sociological, commercial and statistical data”, all coloured with the lens of religion and caste.²⁴⁰

Like the Indian census, the Indian asylums survey was derived from a British source. Sir James Clark authored a list of questions, entitled “Care and Treatment of Lunatics” in the middle of the 1860s, and this list was distributed in 1868 to the relevant officers in the British Raj. Clark was an Edinburgh-trained physician, who had been appointed as the Queen’s “Physician-in-Ordinary” upon Victoria’s accession to the throne in 1837. After publishing a number of texts and establishing the Royal College of Chemistry in 1845, he began serving on the General Medical Council in 1858, the same year the East India Company was dissolved and British Parliament took over governance of India.²⁴¹ His friendship with Dr. John Connolly, one of the founders of the British Medical Association and who was famous for popularizing William Tuke’s system of non-restraint in English lunatic asylums, led to Clark’s casual interest in psychiatric medicine.

When Connolly died in 1866 and his son-in-law, Henry Maudsley, wrote a rather unsympathetic obituary, Sir Clark began collecting information to demonstrate the impact of his friend’s “humane” work within lunatic asylums. This led to Clark’s sending a list of queries to the Colonial Office, the Foreign Office and the India Office, asking about the state of care and treatment in any existing lunatic asylums in their countries. As Secretary of State for India (head of the India Office), Sir Stafford Northcote submitted

²⁴⁰ Scholberg, *The District Gazetteers*, vi.

²⁴¹ As an interesting coincidence, the General Medical Council was formed as a result of passing the Medical Act of 1858 (21 & 22 Vict., c. 90), on 2nd August of that year; this is the same date that the Government of India Act (21 & 22 Vict., c. 106) was passed.

Clark's queries to the India Home Department, who distributed Clark's list almost without alteration.²⁴² The questions were split into six sections: buildings, medical care, ordinary attendants, treatment, forms of insanity and complications, and general queries. The responses were collected and published by the end of the year. While Sir Stafford Northcote and the Home Department had authority over the survey, it seems Sir James Clark was one of the first to receive the results in England.²⁴³

The survey was an initial attempt by Clark to assess the degree to which Connolly's system of non-restraint had been conveyed into the colonies. It was also a chance for the government to provide a concept of lunacy in the Indian population, to aggregate individuals by a formal definition (their diagnosis of insanity) and give them characteristics based on psychiatric categories from Western Europe. Just as the Indian census behaved so that religion became mapped onto communities, who were counted and compared with other Indian communities,²⁴⁴ the survey allowed for local and British ideas of insanity to be mapped onto the communities that inhabited the asylum, permitting 'native' and British lunatic asylums, in theory, to be compared. In the Indian census, the new conceptualization of religion as community flowed back from census reports to the Indians who were initially just the subjects of those reports. In the asylum

²⁴² Only question "I." under the final section, "General Queries", was adjusted to ask specifically about "caste" as well as "rank".

²⁴³ The information gleaned from the survey was conveyed to Sir James Clark ahead of the publication of his memoir of John Connolly, and before even Northcote had had a chance to evaluate the results. In Appendix C, he writes, "A series of queries regarding the treatment of the insane throughout our dominions in India was circulated about two years ago, by order of the Right Honourable Sir Stafford Northcote, Secretary of State for India in Council... a summary of the information, which the inquiry referred to yielded, will be submitted to the Secretary of State for India as soon as it can be prepared." James Clark, *A Memoir of John Connolly: Comprising a Sketch of the Treatment of the Insane in Europe and America* (London: John Murray, 1869), Appendix C, 297-298.

²⁴⁴ Jones, "Religious Identity," 23.

survey, the superintendents acted as subjects and objects of Clark's questions. Thus, the survey was both an attempt to uncover the care and treatment of lunatics in India and a mapping of multiple notions of insanity.

The timing of the survey was key. A mere ten years after the 1858 Lunacy Laws were enacted, the Government of India sought the results of its experiment with 'native' lunacy. The survey was distributed in April 1868, and the results were collected and collated within the year. Arguably, the Government was economically and administratively invested in the success of this experimental institution. The survey responses reveal a large and variable group of actors, some of whom were discussed in the previous chapter, who overlap with the actors acknowledged in the Annual Reports and formed an intricate network with the colonial asylum at their centre. The survey allowed the government to gauge the temperature of each institution, permitting each site to 'speak' through the voice of the responding superintendent, without being obscured by superficial commentaries that collated the asylum into discussions of colonial hospitals or prisons of the period.

What does it mean for an institution to speak? I am building on the work of Bruno Latour and of Timothy Mitchell, to use the asylum survey as an effective actant and historical source in my narrative. In a chapter entitled "Can the Mosquito Speak?", Timothy Mitchell argues for the interconnectedness of human and non-human agency. For Mitchell, human agency alone is insufficient in explaining the historical course of the development of Egypt as a state, and this argument can be applied to many other cases. In this history of the 'native' lunatic asylum, British and Indian agency do not, by themselves, explain the function and trajectory of lunatic asylums in India between 1858

and 1912. I would argue that Connolly's death in 1866 sparked Clark's survey of 1868 to catalyse the role of the native lunatic asylum in Crown-ruled India. Connolly's fatal stroke, the flooding of the Patna Asylum by the Ganges, and the Orissa famine of 1866, all provided ecological and environmental contributions to the development of the native asylum.

Mitchell's work is even more effective in this chapter when we consider it alongside Latour's Actor-Network Theory (ANT). ANT promotes objects (actants) to having equal analytical value as humans (actors) within a particular network. The asylum, as a physical space, was significant in how patients, attendants, superintendents and community members interacted with each other; the survey was both a reflection and a cementing of this space.²⁴⁵ Social historian Steve Shapin would argue that the native asylum was a sociology of space, a spatial structure constituted by the interactions between its social elements.²⁴⁶

The survey is a useful lens into these Shapinian and Latourian spaces, constructed as they were by multiple actors and the implementation of a number of colonial policies. The survey is perhaps more useful to modern scholars for its demarcation of a moment when the still-nascent government actively sought information about an experimental kind of colonial institution, behind which it had not placed a great deal of thought. The

²⁴⁵ Mitchell was, of course, expanding upon Gayatri Spivak's question, "can the subaltern speak?" Timothy Mitchell, "Can the Mosquito Speak?" in *Rule of Experts: Egypt, Techno-Politics, Modernity* (Berkeley: University of California Press, 2012), 18-51. Latour's ANT has been particularly influential in history of science, but other frameworks exist that allow non-human entities to be agents in a community, such as in anthropology. Bruno Latour, *Reassembling the Social: an introduction to actor-network theory* (Oxford; New York: Oxford University Press, 2005).

²⁴⁶ Shapin has called for a more vigorous examination in the geography and space of knowledge. See, S. Shapin, "Placing the View from Nowhere: Historical and Sociological Problems in the Location of Science," *Transactions of the Institute of British Geographers* 23, 1 (1998): 5-12.

survey also worked as a point of contact between many superintendents, who had never corresponded with each other but had opportunity to compare and self-identify as a community²⁴⁷ in their reports. With the survey, superintendents were forced to reflect on their management practices, their involvement with the local communities and the effectiveness of asylum medicine. In what follows, I attempt a sociology of the asylum space in India, using the 1868 survey as my primary source.

“Were these [buildings] originally designed for a Lunatic Asylum?”

The section entitled “Buildings” inquired about the date the asylum was established, the square footage, the number of rooms, wards or dormitories, the materials used, the history of each building, and extra information, e.g. the architecture. The structure of the asylum was often compared with that of nearby prisons, and the geographic location was also represented in terms of proximity to jails. For example, Surgeon-Major R. Cockburn, superintendent of the Benares Lunatic Asylum described the “situation” of the asylum as being “In the Benares Civil Station, adjoining the District Jail”.²⁴⁸ Officiating Superintendent of the Bareilly Lunatic Asylum, J. C. Corbyn, instead described his institution in terms of “barracks”, one of which was “set apart as hospital”.²⁴⁹ Similarly, the Civil Surgeon in charge of Delhi Lunatic Asylum, J. C. Penny, described the asylum as being “about 200 yards from the Delhi Jail, which is about 1,000 yards from the Delhi Gate of the city.” In fact, the Delhi Lunatic Asylum “has been and is

²⁴⁷ See chapter 2 for further details.

²⁴⁸ S-M Cockburn, Suptdt, Lunatic Asylum, Benares – No. 32, dated the 30th June 1868, *Care and Treatment of Lunatics in India*, Home Department, Public A, 19 December 1868, NAI.

²⁴⁹ Corbyn, M.D., - No. 51, dated the 21st May 1868, *Care and Treatment of Lunatics in India*, NAI.

now partially used as workshops for prisoners confined in the neighbouring jail, the prisoners being quite apart from the lunatics.”²⁵⁰

The proximity of and relationship to nearby prisons is the most explicit manifestation of the blurring between asylum and prison jurisdiction. The counterpoint between ‘mad’ and ‘bad’ continued throughout the nineteenth century, and forms the focus of the next chapter, but was particularly pertinent in the asylums located in border cities and towns. Although Lucknow was the site of one of the more significant rebellions in 1857, its asylum was not built near the prison and the superintendent, J. C. Whishaw, wrote a very detailed response to the survey without any mention of district jails or criminal populations.²⁵¹ Only the asylum at Patna was originally built “at the commencement of the present century as an Asylum for Natives”, in keeping with the birth of the European-only asylums in colonial India.²⁵² However, its attachment with the old Civil Jail led to it rapidly becoming overcrowded with Indians described as “criminal” rather than “insane”; only with the 1858 Lunacy Acts was its original function restored.²⁵³

The survey reveals the wide variety of buildings that made up ‘native’ asylums in India. Not only did the buildings range in terms of their original function, but they also

²⁵⁰ Penny, Esq, Civil Surgeon – No. 59, dated the 8th June 1868, *Care and Treatment of Lunatics in India*, NAI.

²⁵¹ This evidence further counters the idea that lunatic asylums were established soon after 1857 and 1858 to contain and stigmatize rebellious elements within the Indian population. Whishaw, 12th August 1868, *Care and Treatment of Lunatics*, NAI.

²⁵² Waltraud Ernst, *Mad Tales of the Raj*, 1991. Ernst’s work neatly bookends my own, her having explored the European asylums in India before 1858, and then the rise of new psychiatric institutions after 1912, with Ernst, *Colonialism and Transnational Psychiatry: The case of the Ranchi Indian Mental Hospital in British India, c. 1920-1940* (London: Anthem Press, 2013).

²⁵³ G. Saunders, M.D., Deputy Inspector-General of Hospitals, Lower Provinces – 28th May 1868, *Care and Treatment of Lunatics in India*, NAI.

diverged in terms of number and type of facilities available at each site. Over half the asylums in the survey reveal that the buildings in existence were never originally intended to house insanes. Most often these buildings existed before Crown Rule (and sometimes before Company rule, too) and were simply appropriated from the land. Buildings that had been constructed by the British before 1858 for other purposes were converted into *ad hoc* institutions that befitted local and colonial needs. The Dacca [sic] Lunatic Asylum, for example, was first “a fort built by the Mohamedans”, then “an elephant stable”, before being converted to an asylum on the northern edge of the public market.²⁵⁴ The overseeing superintendent was very dismissive of these converted buildings:

The buildings at present occupied by the lunatics cannot have been originally designed as abodes suitable for them. There is such an entire disregard shown of elevation, ventilation, and aspect, that it is more probably that the old buildings in the Native fort were altered and adapted to their present use... There are only two walled airing yards attached to the asylum. Being surrounded by lofty walls, they are very hot and close, and are ill-adapted for the recreation of lunatics.²⁵⁵

In the Central Provinces, the unnamed superintendent of the Government Lunatic Asylum at Jubbulpore wrote that the asylum had been “originally built for a charitable dispensary, but being in a remote, rather unfrequented, part of the city, they were converted into a Lunatic Asylum”. Moreover, there were “three single rooms for males to seven dormitories, and one single room for females to two dormitories” as well as “three walled

²⁵⁴ James Wise, Esq., Superintendent of Lunatic Asylum, Dacca – 24th June 1868, *Care and Treatment of Lunatics in India*, NAI.

²⁵⁵ *Ibid.*

airing-yards for males, and one for females”, “two wells of good drinking water” and 480 feet of verandahs.²⁵⁶

Lahore Lunatic Asylum was “built by the Sikhs during their rule and used by that Government as a Military depot or magazine for stores”. It had:

3 walled airing yards: size 257 x 180, 160 x 190, and 186 x 342 feet. There is an ornamental flower garden within the Asylum walls, and a large vegetable garden outside in which the patients are employed; there is also a workshop for all such as are able to work at their respective trades, - a light occupation being found to have a most beneficial effect; these grounds on an aggregate embrace an area of four acres, two roods, and 26 poles.²⁵⁷

Many asylum superintendents were eager to describe the gardens and land attached to the buildings. Yet even though asylum architecture was a very fashionable topic in England and on the East Coast of America, we do not see a similar conversation occurring in colonial India. Nancy Tomes’ examination of Thomas Kirkbride – probably the most significant figure in the history of American asylums – reveals the importance of asylum architecture to local communities’ acceptance of these institutions as useful and desirous for the care of their insane relatives. Kirkbride combined earlier ideas of moral treatment with an environmental or architectural behavioural programme of treatment.²⁵⁸ William Tuke instigated a similar conversation in England, where the form of the asylum (i.e. its architecture and grounds) behooved the function (the treatment). The idea of form

²⁵⁶ Superintendent of Government Lunatic Asylum at Jubbulpore, 4th July 1868, *Care and Treatment of Lunatics in India*, NAI.

²⁵⁷ C. M. Smith, Esquire, FRCS, Civil Surgeon, in charge of Lahore Lunatic Asylum – dated the 4th July 1868, *Care and Treatment of Lunatics in India*, NAI.

²⁵⁸ Nancy Tomes, *A Generous Confidence*, 1984. Tomes also overcomes the oft-repeated dichotomy between the asylum as an institution for controlling disturbed members of society or simply providing care for vulnerable patients by suggesting that the rise of the asylum in C19 America corresponded with changes in local families’ willingness and ability to care for disturbed relatives. Kirkbride was said to ‘cultivate his patron’s generous confidence’ using the beautiful sight of his asylum, as well as his rhetoric. Families wanted both control and care for their relatives, and Kirkbride was able to use the form of the institution to convince them of its function.

following function came from Tuke's religious principles: as a Quaker, a routine of useful activities in civil spaces was the best treatment for a wandering mind. Tuke's York Retreat allowed asylum patients to perform functions in a routine way, accompanied by disciplined and pleasant gardens that encouraged these patients to internalize their surroundings. The grandeur of the York Retreat's grounds also reassured families and encourage them to volunteer their relatives into the asylum.²⁵⁹

In contrast, few superintendents responding to Sir James Clark's survey remark on the architecture or grounds of their asylums as opportunities for treatment. Only the Benares asylum superintendent reports on the structure of his institution: it was originally constructed in 1812 but had long been condemned and disused as unsuitable for the purpose of therapeutic care. Instead, "arrangements for the erection of a new [building] based on the cottage system on a different site with ample grounds for exercise, &c., have been nearly completed."²⁶⁰

"Is the Asylum visited by others than those immediately in charge; and if so, by whom, and at what intervals?"

The second survey section was titled "Medical Care". By this, the inquiring officials truly meant "medical", not psychiatric, and personnel instead of "care". The survey made in-depth inquiries into who comprised the official British staff caring for the lunatics, as well as the bodily health of each patient: how many doctors were in residence, how often did they receive European patients, were female doctors present, and what kinds of diseases frequented the asylum? Such rigorous questioning of the

²⁵⁹ Anne Digby, *Madness, morality and medicine*, 1985.

²⁶⁰ Surgeon-Major Cockburn, Benares; *Care and Treatment of Lunatics in India*, NAI.

bodily health of the asylum – in a survey originally distributed to focus on the treatment of lunatics – demonstrates the propensity to privilege bodies and professional medicine over other forms of knowledge, even amongst lunatics. A nineteenth-century physician might argue that the body, and its somatic diseases, constituted the entire scope of health. Physicians and alienists (as nineteenth-century psychiatrists were known) often engaged in professional and intellectual battles over what constituted disease within the medical realm. Puerperal insanity, for example, was a common diagnosis for postnatal women in the latter half of the nineteenth century, but whether the cure lay in doses of chloral hydrate and regular attendance of her gynecologist, or in admission to an asylum under an alienist, was constantly fraught with tension.²⁶¹ Neurasthenia was another common nineteenth-century diagnosis, and the professional tension to label it a physical or mental disease was manifest in the method and site of its treatment.²⁶² The prominent position afforded to questions of medical care in the asylum survey certainly demonstrated how important somatic and bodily health was to the British Government of India.

Naturally, this predilection towards somatic health in the colonies has a history. There were a huge number of sites at which Indian health could be observed from the first half of the nineteenth century, and onwards: dispensaries, ‘native’ hospitals, and clinics at the many British cantonments. With the rise of interventionist policies, to

²⁶¹ Nancy Theroit, “Diagnosing Unnatural Motherhood: Nineteenth-Century Physicians and ‘Puerperal Insanity’,” *American Studies* 30, 2 (Fall 1989): 69-88.

²⁶² The history of neurasthenia extends from the nineteenth century through to World War I, and even into the psychology profession’s Diagnostic and Statistical Manual in 1980. Americans were thought to be especially vulnerable to neurasthenia, so much so that the disease was given the nickname, “Americanitis”. Some noteworthy texts on this subject are: Tom Lutz, *American Nervousness, 1903: An Anecdotal History* (Ithaca: Cornell University Press, 1991); Francis G. Gosling, *Before Freud: Neurasthenia and the American Medical Community, 1870-1910* (Urbana: University of Illinois Press, 1987); and Marijke Gijswijt-Hofstra and Roy Porter’s edited volume, *Cultures of Neurasthenia: From Beard to the First World War* (Amsterdam; New York: Rodopi, 2001).

protect British officials and their families during times of plague or epidemic disease, these sites expanded to include traveling clinics and increased surveillance of health in other colonial institutions, such as prisons and schools. Mark Harrison has argued that a close relationship developed between imperial power and Western medicine, with the latter being a prophylactic and curative arm of the former.²⁶³ David Arnold alludes to this powerful relationship in his examination of the colonization of the Indian body under British rule. He argues that Western medicine was a vital “tool” for the implementation of Westernized governance, and the various institutions dedicated to the distribution of this medicine (e.g. hospitals and the Indian Medical Service) helped to create “colonial enclaves”, where Western medical policy could monopolize existing medical systems.²⁶⁴ Rather than an outright rejection of local medical systems, however, biomedicine’s disciplinary boundaries expanded to accommodate indigenous medicines at a local, rather than state-wide, level.

Poonam Bala has conducted a significant amount of research to show how Western medicine (and its predilection for somatic health) appropriated key elements of Bengal’s pluralistic medical systems and distanced itself from other forms, to become an “oligopoly”.²⁶⁵ However, this was only important for those issues that had repercussions for the health of British officers and their families in the cantonments. Placating and accommodating local systems of knowledge was important for the British colony’s public health, but mental health, which, as a rule, was not contagious or likely to communicate

²⁶³ Mark Harrison and Biswamoy Pati (eds.), *Health, Medicine and Empire: Perspectives on Colonial India* (Hyderabad: Orient Longman, 2001).

²⁶⁴ David Arnold, *Colonizing the Body*, 103.

²⁶⁵ Poonam Bala, *Imperialism and Medicine in Bengal: A Socio-Historical Perspective* (New Delhi: Sage Publications, 1991), 92.

from the local population, was not part of this agenda. Public health was necessary for better governance, but lunacy was not. Instead the ‘native’ lunatic asylum represented a site in which the British government could extend its arm, via Western medical knowledge. The asylum survey promoted this agenda with the prominence it afforded medical care and medical personnel at each asylum. Without a strong doctrine of psychiatric expertise to reinforce these agendas, the government was forced to accommodate local belief systems. At the site of the native lunatic asylum, then, the government was unintentionally oligopolic.

Starting with the medical hospitals of early nineteenth-century and coupled with the strong tradition of allopathic medical care in Western Europe, both medical and non-medical personnel would have had no difficulty in viewing and ascertaining the health of the asylum patients at each site. Asylum superintendents responded to this section of the survey with ease, detailing the number of doctors or medical men with any responsibility towards the asylum. For example, at Jubbulpore there was “a Native Doctor solely for the Asylum, who [was] also resident on the premises.” A Civil Surgeon was also appointed to oversee the asylum, but visited predominantly when “the Native Doctor summons him on account of a serious case.”²⁶⁶ The survey revealed whether these medical personnel were regular visitors of the asylum, or if the asylum was but one of his many duties. The British Civil Surgeon at Jubbulpore was less attentive to the asylum than the Native Doctor, due to the latter residing there. It is likely that the Civil Surgeon lived quite far from the institution, and had little recompense for the costs of traveling there. This contrasted with Benares Lunatic Asylum, whose Civil Surgeon, “who is called

²⁶⁶ Superintendent of Government Lunatic Asylum at Jubbulpore, 4th July 1868, *Care and treatment*, NAI.

‘Superintendent’... has the various other duties of his post; the Native Doctor has no other duty.”²⁶⁷ Owing to the size of Benares, the Superintendent lived only 200 yards from the asylum, which meant he was much more involved with the asylum than his counterpart in Jubbulpore.

In Moydepore, the differences between the expectations and responsibilities of the Medical Officer and the Native Doctor were even starker. The asylum superintendent wrote with self-pity that he, the “European Medical Officer” was “Civil Surgeon of Moorshedabad”, and as a result:

[H]as medical charge of the Jail Police Hospital, Lock Hospital, superintendence of three Dispensaries, attendance on Government Officials and their families, charge of a large District Police Force, some 1,200 strong, and has to make inquests, besides many other miscellaneous duties, too numerous to detail, constantly imposed on Civil Surgeons.

For months together, too, it sometimes happens that he is the only Medical Officer in Berhampore, when he is called on to perform both the Civil and Military duties of the Station.

The Native Doctor’s duties are confined to the Asylum.²⁶⁸

Several “ex-officio” Visitors were entreated to visit the asylum regularly, to compensate for the lack of a proximal and available Native Doctor and Civil Surgeon. These Visitors ranged from the local Judge, the District Superintendent of Police, Military Medical Officers and ordinary Civil Officers. However their visits were also “rare, owing to the distance of the Asylum from the [Military] Station, and then generally being fully occupied with other work.”²⁶⁹ The asylum superintendent at Patna also bemoaned the rarity of medical and administrative visits: “The Asylum is supposed to be visited

²⁶⁷ Surgeon Major Cockburn, Superintendent, Lunatic Asylum, Benares – No. 32, dated the 30th June 1868, *Care and treatment*, NAI.

²⁶⁸ Surgeon Major A. Fleming, Civil Surgeon, Moorshedabad, 15th July 1868, *Care and treatment*, NAI.

²⁶⁹ *Ibid.*

monthly by the official visitors, of whom there are eight, but the Deputy Inspector-General of Hospitals is the only one who pays regularly monthly visits”.²⁷⁰ As a result, the Native Doctor and the other asylum staff had to manage and treat the somatic health of their patients without a great deal of help from their superiors.

Only one asylum superintendent responded dismissively to Clark’s questions in this section, stating that the facts about his asylum patients’ bodily health could be surmised from the Annual Reports. Arthur Payne, of the Lunatic Asylum at Dullunda, in Bengal, was explicit about there being one Medical Superintendent, who was also responsible for the European Asylum nearby, but all other details and duties were “specified in the Asylum Report”. Payne quickly moved on to discussing Ordinary Attendants and the other sections of the survey, with a brief note that the Annual Report for Bengal Lunatic Asylums was appended to his response.²⁷¹

Thus the asylum Visitors and British medical staff were integral to maintaining a British presence in these colonial institutions, but they were not always equipped or willing to act as the oligopolic arm of the government. Sometimes they were not invested in the imperial function of the asylums, or at other times their other charges – for example, the asylum’s related institutions, the prison and the hospital – took precedence. This left the responsibility and daily functioning of the asylum to their subordinates: the “Ordinary Attendants”.

²⁷⁰ G. Saunders, M.D., Deputy Inspector-General of Hospitals, Lower Provinces – 28th May 1868, *Care and treatment*, NAI.

²⁷¹ A.C. Payne, Dullunda, 17th June 1869, *Care and treatment*, NAI.

“Are escapes frequent?”

After detailing the buildings and medical care that constituted the asylum, the survey then turned to “Ordinary Attendants”. By this, the surveyors meant “natives”. I first examined this population in the previous chapter, although the asylum reports only afforded very specific information about a few native attendants. In contrast, the survey was an attempt to enumerate all the native attendants, by gender (i.e. “Are there male attendants for male patients, and female attendants for female patients?”) and by ratio (i.e. “What is the proportion of attendants to patients?”). For those asylum superintendents who did not see heterogeneity within their native staff, these were easy questions to answer. In Benares, the superintendent simply responded “Yes” to the first question, and “Variable” to the second.²⁷² In Jubbulpore, the superintendent was similarly brief in his answers to this section, but did explain that “the female patients are too few to require a special attendant”, so he himself acted as an attendant if and when female patients were received.²⁷³ The Delhi Asylum superintendent referred to these ordinary attendants as “warders”, and simply wrote that there was just one for every eight patients.²⁷⁴ In contrast, the superintendent of Bareilly Lunatic Asylum was very detailed in his response:

The servants and guards are entertained on a fixed ratio, and increase or decrease according to the number of inmates in the Asylum, *vide* following:

- 1 Naib Jemadar for every 30 patients
- 1 Peon or Burkundauze for every 8 patients
- 1 Mater for every 20 patients
- 1 Barber for every 50 patients

²⁷² Benares, 12th April 1869, *Care and treatment*, NAI.

²⁷³ “Jubbulpore”, *Care and treatment*, NAI.

²⁷⁴ “Delhi”, *Care and treatment*, NAI.

1 Cook for every 40 patients.²⁷⁵

From this information, it is clear that ordinary attendants held variable significance across the native asylums in India. The terms used to describe them say as much about the superintendents as they do about the attendants themselves. To describe the native staff as “warders” is to suggest a strong overlap with the men who worked as attendants in the native prisons: warders were in charge of prisoners, and had authoritative and punitive roles. Despite a number of ongoing prison reforms in India at this time, native prisons were dismissive of the idea of the prisoner as an individual, and warders were recruited to enforce the idea of prisoners as units within the administrative machinery of the Indian jail.²⁷⁶

Many of the men recruited in prisons were transferred to working in asylums, and such warders were often rebuked for mistreating their insane wards. In Jubbulpore, the superintendent had a warder “sharply punished... also dismissed” for striking a patient. Jubbulpore’s superintendent was not insensitive to the different needs of an asylum versus a prison, and criticized the transferring of “such men who come from the Lock-up [jail]” and who were “without consideration of the... convalescent and vulnerable insanes” in their care.²⁷⁷ In contrast, a *jemadar* was a rank used by the British Indian Army to describe men who assisted their British commander and filled respectable regimental positions: to bestow the title of *jemadar* upon an ordinary asylum attendant

²⁷⁵ “Bareilly”, *Care and treatment*, NAI.

²⁷⁶ It was only in the twentieth century that prison reform truly brought attention to prisoners’ material wellbeing and health in India, and then only because of comparative work with prisons in Japan, the Philippines and Hong Kong. Amarandra Mohanty and Narayan Hazary, *Indian Prison System* (New Delhi: Ashish Pub. House, 1990), 26.

²⁷⁷ “Jubbulpore”, *Care and treatment*, NAI.

was either a sign that he had come from an obedient and assistive background, or that he was responsible and responsive to his superintendent, as a *jemadar* would be to his commander. The attendants were local men (and sometimes women) recruited from nearby towns and villages, however in moving between colonial institutions, they carried with them a mixture of local beliefs and British colonial agendas. Building on the earlier discussion of complicity and agency, we can describe this inter-institution mobile workforce as both complicit with the local government's intentions in agreeing to work wherever the colonial need was greatest, and also as having agency in the management and treatment of asylum patients. Depending on their location, this attending workforce was an extension of its British superiors, but they could also be held accountable, as distinctly differentiated men and women, with particular responsibilities of their own.

This section of the survey made explicit inquiries about the numbers of escapes and suicides in each asylum. The fact that such information was examined in this section, alongside numbers of ordinary attendants, suggests that the responsibility for escapes and suicides fell upon the native staff, and not the European or British doctors and official visitors. Happily, most superintendents reported escapes as being few, and suicides even less common. In Nagpore, "escapes are not frequent, but sometimes a patient will wander away and return of his own accord."²⁷⁸ Similarly, in Lahore, escapes were not frequent, and "those who do escape are either found by the Police or return of their own accord."²⁷⁹ The Jubbulpore asylum superintendent used the lack of escapes and suicides as demonstration for the pleasantness of his asylum and his staff's ethos:

²⁷⁸ Superintendent of the Government Lunatic Asylum, Nagpore, to the Officiating Secretary to the Chief Commissioner, Central Provinces – No. 65, 19th June 1868, *Care and treatment*, NAI.

²⁷⁹ "Lahore", *Care and treatment*, NAI.

It has been part of the system observed at this Asylum to encourage the inmates to do as much as possible for themselves, as if they were in their own houses. This gives them occupation, diverts their thoughts from their unhappy condition, gives them the idea that they are under no restraint and fosters no wish they may have to be released.²⁸⁰

Escapes were not the only means by which patients left the institution. The Bareilly Lunatic Asylum superintendent wrote that “one man committed suicide in 1865 by *regularly* squeezing himself through the gratings of the well.”²⁸¹ At Delhi, the superintendent was unperturbed by the rate of suicide in his asylum: “Suicides are not uncommon in a large Asylum. The Delhi Lunatic Asylum being in its infancy affords no ground for an opinion.”²⁸² The desire to leave an asylum by means of death is telling – especially if patients attempted suicide *regularly* – but the superintendents’ responses to these suicides is also telling.

Attendants were chastised for permitting escapes and for not preventing suicides, which suggested that, for all the conviviality of the community, Indian staff were held accountable over British failings.

“Is mechanical restraint employed?”

The next section of the survey was much more extensively answered than that of the Ordinary Attendants. “Treatments” asked superintendents about physical treatments, such as restraint or pharmaceutical compounds, as well as patients’ dietary intake. Superintendents used this section also to detail the hygienic practices of some of their “dirty” patients. Nagpore, Patna, Jubbulpore, Benares and Lahore all reported no use of

²⁸⁰ “Jubbulpore”, *Care and treatment*, NAI.

²⁸¹ “Bareilly”, *Care and treatment*, NAI.

²⁸² J.C. Penny, Delhi, 8th June 1868, *Care and treatment*, NAI.

mechanical restraint, strait-jackets, hand-cuffs and fixed chairs. Most of the asylum superintendents also reported no padded rooms or cells for solitary confinement. Jubbulpore's superintendent even suggested that the available single rooms were sometimes "given to a patient to sleep in as a reward for good conduct".²⁸³ Such rooms were not rewards in Delhi Asylum, where the superintendent believed "three dark rooms are [necessary] for solitary confinement", especially for patients that were violent. He had also found "occasion to put hand-cuffs on a patient" until "the violence of the paroxysm is over".²⁸⁴

In Benares, "hot mustard baths" were sometimes used for "tranquilizing effect" but "usually a cold shower-bath from a mussuck is used". A mussuck was a leather-skin that was used to hold a volume of water over the patient's head, and release the liquid slowly, like a modern-day shower. The use of baths, of varying temperature, was common: in Nagpore, cold baths were "daily used" to clean and treat insanes, while in Patna, a cold douche was "fundamental" to "invigorate" patients' minds and "allaying excitement", unless they were convalescing (in which case, "warm baths" were more effective).

It seems there was no consistent idea being expounded in all of the asylums. One superintendent was explicit about his theory of asylum management: moral treatment. In Lucknow, J.C. Whishaw, Officiating Civil Surgeon and Superintendent, wrote a separate document, preceding the asylums survey by a year, titled *Rules for the Management and Control of the Lunatic Asylum at Lucknow*, in which moral treatment was significant.

²⁸³ "Jubbulpore", *Care and treatment*, NAI.

²⁸⁴ "Delhi", *Care and treatment*, NAI.

“It must be borne in mind that the moral treatment is of equal importance with the medical, and that much may be effected towards the recovery of the afflicted by the healthful employment and exercise of mind, and the careful banishment or avoidance of any habitual or irritating train of thought, by suitable employment, innocent games, and by means of recreation. The means best fitted for the useful occupation and amusement of patients, as well as the medical treatment, must be left to the decision of the Superintendent.”²⁸⁵

In Bareilly, a similar sentiment existed: “The patients are managed entirely by kindness and firmness, order, regularity, and occupation, with of course medical treatment, good food and cleanliness.”²⁸⁶

Sir James Clark was probably motivated to ask this question to engender direct comparison with the moral treatment he knew to exist in Britain. The phrasing of the question is leading, and the language used in their answers suggests the asylum superintendents were familiar with this system of treatment. The superintendents spoke frequently of the use of occupation as a form of remedy in this section, but they were just as concerned with the location of latrines in the ground, and their familiarity with the phrase, “moral treatment”, is not sufficient evidence to argue that this was the system they implemented in their own asylums.

James Wise, of Dacca Lunatic Asylum, described every outdoor occupation as “healthy, and at the same time suited to the classes of population which furnish the large majority of the inmates.”²⁸⁷ Surgeon Major A. Fleming, superintendent of Moydepore Lunatic Asylum of Moorshedabad, remarked on patients’ use of the grounds even more

²⁸⁵ Whishaw, 6th June 1867, Lucknow, *Care and treatment*, NAI.

²⁸⁶ “Bareilly”, *Care and treatment*, NAI.

²⁸⁷ “Dacca”, *Care and treatment*, NAI.

briefly: “all are occupied in some way or other”.²⁸⁸ The superintendents responded to the survey questions with a great deal of information, which suggests they were actively engaged with the success and functioning of their asylums, but they failed to fully apply the ‘modern’ treatments that were being implemented by James Clark, among others, in Britain.

In order to be effective, the ideology of moral treatment had to be present at the time of building of asylum. It was not easy for asylum superintendents in India to overlay moral treatment onto buildings that had not been built with this philosophy in mind. Another argument might be that the Indian mind, being considered so entirely different from the British, was not considered susceptible to the same mental diseases, and therefore the same treatment could not be applied. There was also presumably a natural delay between developments in Britain and developments in India, thus a survey conducted later in the century might reveal more efforts to build moral asylums in the subcontinent.

Of course, moral treatment *could* have been encouraged in these ‘native’ asylums, even without being manifested explicitly in the architecture: new wards and facilities were constantly being added and refurbished in existing asylums, and the superintendent could have embraced moral treatment in these new structures, if not the whole institution. The idea that the Indian mind was so different from the British mind would be an effective argument if it were not for the fact that the entire enterprise of establishing and overseeing a whole series of lunatic asylums just for Indians suggests that psychiatric

²⁸⁸ Surgeon Major A. Fleming, 15th July 1868, *Care and treatment*, NAI.

practices in Britain were considered useful and effective in the colony.²⁸⁹ Finally, the first electric telegraph line in India was started in 1850, permitting the rapid communication of ideas across the subcontinent. By 1861, there were 11,000 miles of telegraph lines, connecting all the metropolises with their subsidiary neighbours. By 1882, there was an active telephone exchange in Bombay, Calcutta, Madras and Ahmedabad, all of which would have permitted very easy transmission of information about moral treatment from England and America, to India. Including the huge volume of letters that were regularly exchanged between India and England, and the speed with which administration in India took action, it was not difficult to implement developments in India soon after their acceptance in England.²⁹⁰

Perhaps the failure to implement moral treatment on a wide scale rested entirely on the lack of psychiatric training underscoring superintendents' management of the asylum. Familiarity with the notion moral treatment was not enough to enact its principles on the ground. Some asylum superintendents were so amused and confused by their patient population, the idea of implementing such a rigorous system must have been overwhelming. Instead, superintendents wrote about the behaviours they observed: "Rarely, does an excited patient knock his head against a wall; for, owing to the wonderful strength of the Native skull, there is but little to be gained by doing so."²⁹¹ And those superintendents with a medical background wrote of the pharmaceutical treatments

²⁸⁹ The fact that the Indian lunacy acts resembled their counterparts in Britain so closely, that the same set of psychiatric terms was applicable Indians exhibiting the same symptoms, and even the hierarchical structure of superintendents and their staff was the same, all confirms this counter-argument.

²⁹⁰ The Indian Post Office was established on October 1, 1837. By 1861, there were 889 post offices handling 43 million letters each year. See Diljit S. Virk, *Indian postal history, 1873-1923: Gleanings from post office records* (New Delhi: Army Postal Service Association, 1991).

²⁹¹ R. F. Hutchinson, Patna, 27th April 1868, *Care and treatment*, NAI.

they employed: “I frequently resort to topical depletion, applying, as needs be, three to twelve leeches to each temple... trust mainly to tartar emetic to allay excitement, not pushing it to emesis.”²⁹²

In this chapter, I have shown the extent to which superintendents responded to the 1868 survey, and have attempted to demonstrate the reasons behind such a survey. I have also shown how we can use the survey to access the rich detail of the superintendents’ everyday lives, rather than assuming the survey was simply another archetypal tool of colonial hegemony. The permeability of the asylum community was not separate to the management of the asylum by its superintendent: both were reflections of the each other. This model was complicated by the overarching jurisdiction of the Medical and Judicial Departments of the British Government, neither of whom maintained absolute authority over the institutions until the end of the nineteenth century. In the next chapter, I complicate this story of permeability and asylum management with details of the legislation that was passed throughout this time period. By illuminating the medico-legal battle for authority over the lunatic asylum, I hope to show that actions on the ground translated into discourse at the administrative level, and how this first intervention by the colonial government became a full investment in the practice of asylum management in colonial India.

²⁹² *Ibid.*

Chapter 4: The Rise of the Psychiatric Expert

Kupulmun Sing was a man who had acquired considerable assets in his lifetime, had multiple wives, and lived in Calcutta with his eldest son (who managed their property). One of Sing's younger sons, who lived elsewhere with his mother, made an application to the High Court alleging that his father was "a lunatic, [...] praying that he be declared to be so," and that the High Court appoint a committee to direct the elder son to give up the property for equal share. The mother of this younger son had attempted to mortgage Sing's estate, and the elder son was unhappy about this. Under Act XXXIV of 1858, the High Court appointed a committee, which found that "the alleged lunatic had for many years now and then been for short periods in such a state of mind as to render it right to detain him at home... but that he was of sound mind at the dates of the [committee] duly appointed." Moreover, as the younger son's mother had "mortgaged his estate without the previous sanction of the Court, the mortgage's suit for foreclosure [is] dismissed."²⁹³

This case, entitled *Court of Wards vs. Kupulmun Sing*, was described alongside many other similar instances of families appealing to the British court-system in India and using the 1858 Lunacy Acts in their assertions. It is remarkable that this case occurred in 1862: in four short years, the 1858 Lunacy Acts had become common parlance among many local families, who – if the list of cases described in the High Court Reports is to be believed – were comfortable applying the legislation to their concerns within the colonial judicial system.

²⁹³ 10 B.L.R., 364; 19 W.R., 164. Quoted in *A Digest of Indian Law Cases: Containing High Court Reports, 1862-1900, and Privy Council Reports of Appeals from India, 1836-1900*, ed. Emile Henry Monnier (Calcutta: Superintendent of Government Printing, India, 1902).

The most remarkable thing in this case, however, is the complete absence of a medical or psychiatric expert to attest to Sing's state of mind. For example, neither branch of the divided Sing family nor the High Court consulted an asylum superintendent, despite Calcutta and the Bengal Presidency having the greatest number of lunatic asylums in the country. Moreover, they consulted no medical officers, despite the high density of such men in the cantonments, government offices and the nearby hospitals. In fact, the appointed committee consisted of three members of the Calcutta Bar, as well as a Mr. J. Graham from the Standing Counsel for the High Court of Calcutta.²⁹⁴ These men were legal experts, and it was normal for these to be the only experts to provide evidence in cases of lunacy such as Kupulman Sing's. These men were only interested in the legal definition of a lunatic, as described in Acts XXXIV and XXXV of 1858: "every person found by due course of law to be of unsound mind and incapable of managing his affairs."²⁹⁵

Act XXXVI, concerned with the establishment of asylums and admission therein, was not of interest in this case. It stated a lunatic was simply "every person of unsound mind and every person being an idiot."²⁹⁶ The Act's description was not concerned with incapacity whereas Kupulmun Sing's case revolved around his competence in managing his affairs. Perhaps the irrelevance of the asylum to this case was the reason why no asylum superintendent was called to testify. However, Acts XXXIV and XXXV called for the signature of a medical doctor to give the alleged lunatic a diagnosis, and this was

²⁹⁴ *Ibid.*

²⁹⁵ Ghosh, *Probate, Minority, Lunacy and Certificate Acts*, 79.

²⁹⁶ *Ibid.*

also not done in this case. The elder son's testimony and the family's experiences were seen as sufficient evidence for the father's sanity: "mental derangement [...] aroused by the recollection of past losses or by the recurrence of family quarrels" was a sporadic occurrence but in general "he was of sound mind."²⁹⁷ Thus, there were no medical or asylum men present for this case; I would argue this is because the notion of the psychiatric expert had not been invented in mid-century British India, and because the legal system and Indian families were seen as sufficient to categorize Indians as having "sound" or "unsound" minds.

This chapter uses events between 1858 and 1912 to illustrate the ascension in status of psychiatric 'experts', and demonstrate how the management of insanity became a significant colonial concern. With time, the ecology of the nineteenth-century native lunatic asylum was erased. By the turn of the twentieth century, administrative interventions into lunacy were commonplace and the superintendents of lunatic asylums rose to be 'experts' in the court-room and the asylum alike. While this chapter looks at how this affected the management of colonial lunacy inside India, the next chapter places these changes in relation to the Empire at large.

Who had jurisdiction over insanity? What kinds of knowledge were considered most important in assessing Indian subjects' minds? Much of my argument is grounded in the existence of discrepancy and disconnect at certain key boundaries: the complex boundary between colonial medicine and colonial law, the administrative limits of the government's Medical and Judicial branches, and the line between sanity and lunacy in this period of time. Just as the native lunatic asylums of mid-century India had a history,

²⁹⁷ Monnier, 10 B.L.R., 364; 19 W.R., 164., *A Digest*.

the discrepancy between medical and judicial ideas about lunacy had its own colonial legacy. The challenge to managing native lunacy in mid-century India was the inability to categorize madness as purely a medical or judicial issue. This chapter describes the overlapping relationship between medical and legal ideology from the time of Thomas Macaulay's 1837 Penal Code to the publication of Major Bryson's Lunacy Manual in 1909. I will show how two dissimilar kinds of knowledge – one with a primarily therapeutic agenda, the other concerned with culpability – converged in the lunatic asylum and under the authority of the asylum superintendent.

While the idea of discrepancy between medicine and law is not new²⁹⁸, it is especially manifest in the case of the Indian native lunatic asylum and the conditions underlining native lunacy in British India. The permeability of the asylum allows us to see moments of disconnect, not just between official administrators in medical and judicial departments of government, but also on the ground in the asylum and everyday institutional practice. As I established in the earlier half of this dissertation, much of the confusion inherent to native lunacy was rooted in the lack of clear and directed purpose for native lunatic asylums in India. Other colonial institutions in this period did not display this kind of confusion: early nineteenth-century British concerns for public health, for example, created dispensaries and vaccination clinics without the need to demonstrate their purpose²⁹⁹; similarly, British concerns over rising 'thuggee' behaviour, among other forms of criminality, were quickly assimilated within Indian caste

²⁹⁸ Guenter B. Risse and John Harley Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5, 2 (1992): 183-205.

²⁹⁹ Sanjoy Bhattacharya, Mark Harrison, and Michael Worboys. *Fractured States: Smallpox, Public Health and Vaccination Policy in British India, 1800–1947*. (Hyderabad: Orient Longman, 2005).

hierarchies and the prison system.³⁰⁰ This is an argument about the presence of experts: British medical officers and British-appointed public health officials were recognized for their coherence as a professional group, and respected for their knowledge, while Inspector-Generals of Prisons were well-paid for their work in criminal institutions.³⁰¹ Without a specific and coherent group of individuals in whom knowledge of the asylum and native lunacy were privileged, the asylum continued to be a colonial institution without purpose. This lack of expertise was resolved in two ways: asylum superintendents assumed responsibility over actions that were initially the responsibility of prison inspectors and lawyers, and psychiatric medicine became a relevant and necessary form of expert knowledge in the colony.

The complex topography of lunacy, situated as it was between medical and judicial departments, is not unique to India: there is a great deal of literature on precisely this complexity in nineteenth-century Europe. Roger Smith, for example, has effectively argued that we look at Codes and Acts for Insanity (such as the M’Naghten Rules in 1843 Britain) as symptoms, not causes, of fundamental shifts in public attitudes towards insanity.³⁰² Smith’s seminal work shows how nineteenth-century England invoked an overriding understanding of insanity as being a disease of irrationality; this produced

³⁰⁰ Several scholars have examined the ‘creation’ of an entire caste of criminal people in British India. Two excellent examples of this are found in Sanjay Nigam, “Disciplining and Policing the ‘criminals by birth’, Part 1: The making of a colonial stereotype – The criminal tribes and castes of North India,” *Indian Economic Social History Review* 27, 2 (June 1990): 131-164; and Amal Chatterjee, *Representations of India, 1740-1840: The Creation of India in the colonial imagination* (New York: St. Martin’s Press, 1998).

³⁰¹ A “Conference of Experts” that was held in 1877 to evaluate prison administration had no shortage of jail officers and lawyers in attendance. Such a conference could never have occurred in psychiatric administration: asylum superintendents had not self-identified or organized themselves as a professional community at this point, and those outside the asylum did not conceive of psychiatric experts either. Indra Jeet Singh, *Indian Prison: A Sociological Enquiry* (Delhi: Bajrangee Press, 1979), 25.

³⁰² Roger Smith, *Trial By Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981), 12.

individuals who were at odds with the Victorian tenets of moral responsibility and will-power.³⁰³ Victorian law, however, was based on the ability to try individuals as rational beings and did not account for the idea that human beings could be irrational.³⁰⁴ Alienists, as European asylum doctors were known³⁰⁵, argued that insanity was not located in the conscious or rational part of the brain; insanity was by definition an uncontrollable impulse. While alienists argued to consider the individual in terms of his or her irrational behaviour, there was no common language between psychiatry and Victorian law.

Michael Ignatieff has suggested that we do not attempt to wholly categorise insanity as either legal or medical. Using the Scottish Enlightenment and eighteenth-century social theorists, Ignatieff argues that the difficulty of the insanity defence was its circularity: the horror of the act was proof of the insanity of the perpetrator. Similarly circular in the legal field, the only possible way of discovering a man's intention was to look at what he actually did.³⁰⁶ The unfortunate premise of insanity in India was the desire to categorise insanity somehow within the confines of existing British administration, rather than creating novel structures and legislation.

³⁰³ Jerome B. Schneewind's account of Henry Sidgwick's *Methods of Ethics* explores the Victorian notions of moral responsibility thoroughly. His compendium provides an excellent account of the Utilitarians, whose philosophies informed a great deal of British policy in India in the middle of the nineteenth century. *Sidgwick's Ethics and Victorian Moral Philosophy* (Oxford: Oxford University Press 1977), 152-190.

³⁰⁴ This was also the case in many courts in British India.

³⁰⁵ That there was a specific term for these doctors is an important difference between British and Indian asylums in this time period. A specific term identifies the British asylum doctors as a group of men with some form of professional coherence. My use of the term "asylum superintendents" renders these British officers in India with greater group identity than they themselves would have acknowledged. There is little positive evidence in the archives that these men felt affiliated with each other. I would argue that they felt a greater affinity with their asylum's ecology than each other until the late 1880s.

³⁰⁶ This idea was encapsulated in "Stephen's Rule". Michael Ignatieff, "An Introductory Essay", in *Wealth and Virtue: The Shaping of Political Economy in the Scottish Enlightenment*, eds. Istvan Hont and Michael Ignatieff (Cambridge: Cambridge University Press, 1983), 1-45.

The comparison with Scottish history is apt. Both Scotland and Ireland borrowed from English legislation a great deal, and the diverging paths that Scottish and Indian lunacy legislation followed is a useful indicator of the other factors affecting the management of insanity in either colony. As in India, the 1845 English Lunacy Act and the 153 County Asylums Act were catalysts for Scottish asylum reform. The 1857 Lunacy (Scotland) Act created a handful of district asylums that were charged with producing Annual Reports.³⁰⁷ Due to differences in geography, Scottish Lunacy Commissioners faced considerable transport difficulties, whether navigating the Scottish Lowland areas, or the more removed Highlands and islands. The overlap between deviance and criminality remained throughout the nineteenth century but, owing to the fact that many of the Lunacy Commissioners were themselves Scottish and the asylums were staffed by Scottish men and women, Scottish asylums did not see the same hybridity of practice as in Indian asylums. Moreover, the proximity of Scotland to England meant that asylums operated more consistently across the British Isles, and lunacy legislation could be enforced more rigorously, too.³⁰⁸

Overview

The history of the Indian Lunacy Acts does not need repeating. Suffice it to say, the Acts were born into a rich milieu of colonial reorganization as well as British and Indian cultural legacies about madness and the mind, which created permeable and hybrid spaces. This milieu also bore the 1861 Indian Penal Code (IPC); however, neither

³⁰⁷ Asylums were established at Aberdeen, Dumfries, Dundee, Edinburgh, Glasgow, Montrose and Perth.

³⁰⁸ Donald Cameron, "Admissions to Scottish Mental Hospitals in the Last Hundred Years," *Brit. J. Prev. Soc. Med.* 8 (1954): 180-186.

the Code nor the prison system exhibited the everyday smorgasbord of ideas and practices that we have seen in the native lunatic asylum in this time. This chapter begins with a history of the IPC to demonstrate the differences between an institution like the asylum and a contemporary penal institution like the prison. The prison embodied the kinds of ideas and practices that allowed it to behave like a typical colonial institution: disciplined, autonomous and impenetrable. Examining the IPC also allows us to see a very tangible difference in the way the colonial government intervened and managed criminality from very early on, as compared to its interventions in lunacy.

How did different branches of government speak to the same issue? After all, lunacy was simultaneously a medical and legal concern. After presenting the IPC and criminal legislation as a useful contrast to lunacy legislation, this chapter suggests that medical jurisprudence was one attempt to marry the diverging views. Dr. Norman Chevers was one of the first asylum superintendents to successfully publish a monograph on lunacy in India. His success was probably due to his publishing on a topic that the legal profession felt was useful: the “science of legal medicine”, as Chevers described it, was an increasingly important concern within judicial circles, owing to the creation of a class of prisoner, the “criminal insane”, after the 1858 Lunacy Acts. Even so, his text was not widely-distributed, and he failed to improve the visibility and status of knowledge on insanity in any significant way.³⁰⁹

Another way we might understand the changing place of lunacy in this period is by using Michel Foucault’s work on *The Abnormal*. By the end of the nineteenth century, there was a growing need for expert psychiatric opinions in the courtroom. In Europe,

³⁰⁹ Norman Chevers, *A Manual of Medical Jurisprudence for Bengal and the North-Western Provinces* (Calcutta: Thacker, Spink and Co., 1856).

these opinions suggested an alternative for the legally responsible individual: psychiatric expertise argued for the presence of “an element that is the correlate of a technique of normalization”.³¹⁰ By this, Foucault meant that the person being assessed was converted into an object of clinical science, “affixed to his or her own individuality.”³¹¹ In nineteenth-century India, there was a complicated medico-legal discourse that arose to determine the fate of the “criminal insane” as well as to settle familial disputes (as we saw in the case of Kupulmun Sing, above). This discourse worked to render the accused subject as an object that could be normalized. There was a tension inherent to this discourse: should the government confine and punish the individual, or should they care for, therapize and treat him? I argue that the result of this tension was determined by which branch of the government had the most effective or most dominant “technique of normalization” in India at the time. In fact, with the creation of the psychiatric expert, and the subsuming of asylum superintendents into that role, at the turn of the twentieth century, the discourse was less about proving the individual was either insane or criminal, and more about asserting the actions of the individual were normal or not.³¹² In other words, by the end of the nineteenth century, asylum superintendents or psychiatric experts had ‘won’ the battle over who had the authority to speak on lunacy, both in the courtroom and in a medical setting.

³¹⁰ Arnold I. Davidson, introduction to *Abnormal: Lectures at the Collège de France, 1974-1975*, by Michel Foucault (New York: Picador, 1999), xix.

³¹¹ This point was reiterated in Michel Foucault’s *Discipline and Punish*, 224-225.

³¹² Foucault describes the experts’ abilities to ask questions and determine the individual as insane or criminal as *un enquête*. Michel Foucault, “La Vérité et les formes juridiques,” in *Dits et écrits: 1954-1988* (Paris: Editions Gallimard, 1994), 1462.

Asylum superintendents' increased authority came as a result of bureaucratic reorganization: European asylums had been funded by the Military department, which initially extended its financial support to funding superintendent wages in the 'native' asylums too. However, the Medical Branch of the Home Department assumed full charge of lunatic asylums in 1873, which also increased superintendents' salaries and improved their training. By the time the penitentiary system had been separated from the Home Department into a clearly delineated Jails office in 1888, the idea that insanity required therapy and not punishment was almost complete. Suddenly the superintendents were the primary group who could speak about insanity, and their administrative proximity to medical officers in other institutions meant that they needed to demonstrate more rigorous training and education.

This chapter ends with a discussion of the growing concern by British officers at large that they did not have a better understanding of lunacy legislation, whether or not they were superintendents of a lunatic asylum. Major Bryson published a *Lunacy Manual* to address this concern. It was published once in 1909, and then again in 1910, each time with greater distribution and success than Norman Chevers' text in 1860. I argue that this difference in success is not merely an artifact of Chevers' text being a different genre (a textbook) to Bryson's (which was a manual): Bryson's text also spoke to the issue of lunacy in a completely different social milieu. This was not the same British India that had borne the 1858 Lunacy Acts and 1861 Penal Code. The Government of India had consolidated its control of the lunatic asylum and relocated the 'place' of insanity in India by unraveling the medico-judicial discourse and placing lunacy entirely in the medical

realm. This had repercussions on the role of the asylum superintendents as medical experts, and irrevocably changed the asylum into a less permeable space.

The Indian Penal Code

The Indian Penal Code (hereafter, IPC) quickly followed the Lunacy Acts of 1858 in 1860. As much of the Code's legislation was at odds with the Lunacy Acts, it would be tempting to argue that "lunacy" had simply been a placeholder for "criminality" and "deviance" in the immediate aftermath of the 1857, with the IPC usurping lunacy law from the 1860s onwards. Certainly, the IPC was a response to the uprisings, and the language of the Code focuses on a concern for public disturbances:

Whoever malignantly, or wantonly, by doing anything which is illegal, gives provocation to any person *intending* or *knowing* it to be likely that such provocation will cause the offence of rioting to be committed, shall, if the offence of rioting be committed in consequence of such provocation, be punished [...].³¹³

Even the simple act of gathering in public could be criminalized, because of the potential for "riot."³¹⁴ As stated in Chapter XIV of the Penal Code:

A person is guilty of a public nuisance who does any act or is guilty of an illegal omission which causes any common injury, danger or annoyance to the public or to the people in general who dwell or occupy property in the vicinity, or which must necessarily cause injury, obstruction, danger or annoyance to persons who have occasion to use any public right. A common nuisance is not excused on the ground that it causes some convenience or advantage.³¹⁵

This section allowed for the punitive confinement of a colonized subject who exhibited any public display of deviance; however, this did not render the subject a lunatic. In fact,

³¹³ Indian Penal Code, Chapter VIII: Of Offences against the Public Tranquility, Section 153, NAI.

³¹⁴ *Ibid.*

³¹⁵ Indian Penal Code, Chapter XIV: Of Offences affecting the Public Health, Safety, Convenience, Decency and Morals, Section 268, NAI.

the IPC rarely acknowledged the 1858 Lunacy Acts at all. How did local families speak to the Lunacy Act so easily within four years, but the colonial administration overlooked the overlap?

The IPC was not simply a response to the native uprising, nor was a legislative overthrow of the Lunacy Acts. Like the 1858 Lunacy Acts, the IPC had a history that preceded 1857. Its history extended back to the 1840s, when British social reformists raised the problem of inconsistent penal legislation across the Indian subcontinent. As such, the Indian Penal Code can be framed as an attempt by Britain to modernize India's primitive criminal justice system.³¹⁶ David Skuy has turned this argument on its head by suggesting that the IPC was in fact "Britain's attempt to modernize its own primitive criminal justice system."³¹⁷ While most IPC histories assume that Britain's justice system was modern and logically organized when it was supplanted into British India, Skuy argues it was just as disorganized and inconsistent as the multi-layered system of courts in India at the time, if not more so. The IPC grew primarily out of a concern with the British justice system, and not with events (e.g. the mid-century uprisings) in India. In this way, the IPC was a legislative experiment on colonial soil.

In 1834, Thomas Babington Macaulay was empowered by the British Parliament to draft a criminal code for India's legal system, which was then operating under the control of the East India Company.³¹⁸ Owing to some mysterious illness that struck the

³¹⁶ See, for example, Ratnalekha Ray, *Change in Bengal Rural Society* (Manohar, 1979); and V. L. Verma, *Development of the Indian Legal System* (New Delhi: Deep & Deep Publications, 1987).

³¹⁷ David Skuy, "Macaulay and the Indian Penal Code of 1862: The Myth of the Inherent Superiority and Modernity of the English Legal System Compared to India's Legal System in the Nineteenth Century," *Modern Asian Studies* 32, 3 (July 1998): 513-557.

³¹⁸ The Charter Act of 1833 created the Indian Law Commission to rectify deficiencies in India's legal system. The Commission appointed Macaulay, and the first task was to codify India's criminal law.

rest of his colleagues on the Indian Law Commission, Macaulay had to finish the Penal Code by himself. This took three years, and he submitted it in 1837.³¹⁹ His mission was “simply this: uniformity when you can have it; diversity when you must have it; but, in all cases certainty.”³²⁰ Where Macaulay had been specially appointed to this task, and imbued the Code with a clear mission, the 1858 Lunacy Acts had been constructed under such a directive. The closest evidence for such a coherent vision can only be found after the IPC, in 1868, with Sir James Clark’s asylums survey. Whereas Macaulay’s principles were evident throughout the process of drawing up the IPC, which was specially constructed with the Indian public in mind, the theory behind the 1858 Lunacy Acts came from a non-colonial context and were not addressed at the time of enactment.

Reform of India’s legal system throughout the nineteenth century was never confined to the East India Company or the British Parliament. English intellectuals, especially the Utilitarians, were extremely influential. The directive mission of the IPC belonged to the legacy of eighteenth-century social reformer Jeremy Bentham, and his disciples: Macaulay adopted Bentham’s principles of codification and drafting techniques to construct a criminal code that was tailored to the Indian context.³²¹ At each point in the

³¹⁹ George Otto Trevelyan, *Life and Letters of Lord Macaulay* (Oxford: Oxford University Press, 1978), 244.

³²⁰ Macaulay made this statement to the House of Commons on 10 July 1833 before he arrived in India. He added that he also did not believe it was possible for all Indians to live under the same law. Thomas Macaulay, *Complete Works of Thomas Babington Macaulay* (London: Longmans, Green and Co., 1898), XI, 579. See also, Richard Lariviere, “Justices and Pandits: Some Ironies in Contemporary Readings of the Hindu Legal Past,” *The Journal of Asian Studies* 48, 4 (November 1989): 761.

³²¹ Skuy argues that codification was originally intended as a remedy for defects in English law; Skuy, “Macaulay and the Indian Penal Code,” 523. Bentham had had English law in mind when he described the ideal vision of a non-corrupt legal profession; Eric Stokes, *The English utilitarians and India* (Oxford: Clarendon Press, 1959), 225, 233.

drafting process, Macaulay was adapting ideas espoused in Britain for the Indian climate.³²²

To accommodate for the fact that the IPC was novel in India, Macaulay included illustrations with each chapter or section of the Code. Illustrations were hypothetical situations that showed how a particular piece of legislation operated. For example, under the definition of murder, Macaulay wrote:

A. lays sticks and turns over a pit, with the intention of thereby causing death, or with the knowledge that death is likely to be thereby caused. B., believing the ground to be firm, treads on it, falls in, and is killed. A. has committed the offence of voluntary culpable homicide.³²³

The need for these illustrations (which were not part of English law) shows how clearly Macaulay saw a difference between his new colonial setting and the English context. Macaulay went as far as saying that English law in general could not be simply transplanted to India, because English law was “framed without the smallest reference to India.”³²⁴

Macaulay’s reliance upon Benthamite principles of codification can be seen in the code itself.

Chapter II (General Explanations), s. 39: A Person is said to cause an effect ‘voluntarily’ when he causes it by means whereby he intended to cause it, or by means which at the time of employing those means, he knew or had reason to believe to be likely to cause it.

Chapter IV (General Exceptions), s. 84: Nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is

³²² In 1887, an English barrister who was also a member of the Indian Law Commission wrote that Macaulay’s Code reflected the form of code that Bentham himself would have written for India. Whitley Stokes, *Anglo-Indian Codes*, vol. 1 (Oxford: Clarendon Press, 1887), xxiii.

³²³ The Indian Law Commission claimed in 1847 that Macaulay’s illustrations were to be read just as “examples in grammar; and as of examples in grammar or in any science, it is not to be supposed that they ever supersede or vary the rule they are intended to illustrate.” Report on Indian Penal Code, 1847, 12, BL.

³²⁴ Report on the Indian Penal Code, 11-12, BL.

incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law.

The code is littered with defined explanations and exceptions to each rule. The exception above is most pertinent to illustrating the importance of the penal system in delineating lunacy. “Unsoundness of mind” was used in the definition of a lunatic in the 1858 Lunacy Acts³²⁵; however, with the IPC having been drawn up as early as 1837 – predating even the English Lunacy Act – it was Macaulay’s Code which initially set the parameters for distinguishing insanity.

Building again on Bentham, Macaulay had hoped to use prison labour to make prisons self-sufficient, and even profitable. In India, just as in England, however, reformists condemned the practice because prison was supposed to teach criminals the irrationality of their behaviour and immorality of their actions. Prison reform was meant to be spiritual, unlike English asylum reform, which believed labour could be therapeutic.³²⁶ Such labour was also disdained within the Indian justice system because of its affiliation to transportation overseas, to Mauritius, or the Nicobar Islands, for example. Distaste for the use of labour in the penal system translated into the amendment of Chapter XVI of the IPC so that “transportation for life” with its associated hard labour became “imprisonment for life”.³²⁷ In contrast, asylum superintendents at various

³²⁵ Interpretation clause (23) of Act XXXV. Ghosh, *Probate, Minority, Lunacy and Certificate Acts*, 92.

³²⁶ Frederic J. Mouat, who appears again later in this chapter, was insistent on this point. *Transactions of the National Prison Reform Congress*, vol. 3, National Prison Association of the United States, 1874, 554.

³²⁷ Indian Penal Code, Chapter XVI: Of Offences Affecting the Human Body, sections 302-307, and 311, NAI.

asylums advocated the use of occupational therapy, and were only concerned with transportation of their charges because so many of them seemed to die en route.³²⁸

The IPC did a great deal of work to segregate and delineate penal knowledge from other kinds of knowledge in the colony. This marked the beginning of a slow process of intervention by the government into delineating insanity and controlling the practice of asylum management. Lacking a significant professional group or vision in colonial asylums, like the alienists in Britain or Macaulay in India, meant that any question about lunacy was reliant upon documents like the IPC for an answer. The lunacy legislation was not sufficient to provide answers at this point in time. David Skuy has argued that the IPC was a British attempt to modernize its own criminal justice system, but I think it also worked to delineate the medical psychiatric system in India. So much of Macaulay's vision carried into the courtrooms, in cases of insanity, that many asylum superintendents and families used the IPC as a point of reference instead of the lunacy acts. Was there a way for the superintendents and families to speak back to the legislation? The next section will explore the initial attempts to create a common language between the judicial and psychiatric domain.

Seeking a Common Language

There were many instances where medical and judicial legislation were required to speak to each other. The courtroom was one of those instances; as in the example above, the lack of a common language meant that Kupulman Sing's family and the

³²⁸ The best example of the different attitudes towards transportation can be seen in a report on the effect of conveying prisoners and insanes by rail. *Charges and accommodation for conveyance of prisoners and insanes in the Oudh and Rohilkhund Railway*. July 1877, Nos. 109-113, Judicial A, Home Department, NAI.

courtroom overlooked psychiatric expertise entirely. Another place that these legislative branches were forced to interact was at the admission to an asylum. In either instance, the lack of a common language meant that deviant behaviour could be framed in multiple ways, and the most dominant “technique of normalization” was the legislation in which the colonial government was most invested. The following quotes illustrate this point quite nicely:

Whoever is found drunk and is incapable of taking care of himself, or is guilty of any riotous or indecent behaviour, in any public street or thoroughfare, or in any place of public amusement or resort, shall be liable, on summary conviction before a Magistrate, to a fine not exceeding twenty rupees, or to imprisonment, with or without hard labour, for a term not exceeding eight days.³²⁹

The question is not, what is his state of mind when under trial for the offence, - then the calmer and saner he is, to confess or defend, the better; but what was his state of mind before and at the time of commission of the deed. This is a matter of evidence. We should therefore utterly and emphatically repudiate the statement that “it is only *after the trial*” (which may take place months after the deed) “that the physician can be justified in *treating* the criminal lunatic.”³³⁰

These excerpts demonstrate the very different attitudes towards deviant behaviour in nineteenth-century British India. The first is a section of the Calcutta Police Act of 1866, which built on the IPC to reprimand social disorder with punitive time in a prison. The second reads very differently, taken as it is from a commentary on a text on medical jurisprudence in *The Calcutta Review*. Medical jurisprudence was one of the first attempts by British Indian officer to create a common language (of colonial order) across medical and judicial branches of government. Where the first excerpt reprimanded an action with a clearly defined form of punishment (a monetary fee or an absolute term in

³²⁹ The Calcutta Police Act, 1866 (Bengal Act IV of 1866), section 68.

³³⁰ Norman Chevers, “Medical Jurisprudence in India,” *The Calcutta Review* CIII: 21.

prison), the second excerpt referred to a process that would render the accused as a “criminal lunatic” for the rest of his or her life.

Dr. Norman Chevers’ text, *Medical Jurisprudence in India*, was “a system for India, intended to be used by those who have already mastered the science of legal medicine, as it stands well-nigh complete for Europe in the works of Taylor, Casper and Guy.”³³¹ In other words, Dr. Chevers, a medical man, was attempting to translate the European “science of legal medicine” for use in British courts in India, similar to the goal of Macaulay when drafting the IPC. Whilst performing the duties of a Civil Surgeon, Dr. Chevers wrote how he was frequently struck with the singularity and intricacy of the medico-legal questions in the subcontinent, for which his opinion was required by the magistrates and judges of the district courts; he deduced that the existing Indian medical literature needed a treatise on medical jurisprudence that embodied clear, enlightened and British explanations for the “various and peculiar modes by which the natives of the country were wont to effect crimes against the person, and to attempt their concealment”.³³² He wanted to illustrate “the many difficult questions regarding unsoundness of mind, identity, suicide, torture, &C., which frequently occur here under circumstances entirely dissimilar to those which call for the like investigations in Europe.”³³³

Dr. Frederic J. Mouat, Chevers’ long-time colleague and Professor of Medicine at the Bengal Medical College, had requested copies of all depositions of Civil Surgeons in

³³¹ *Ibid.*, 2.

³³² *Ibid.*

³³³ *Ibid.*

cases of murder and wounding after 1840 from the court of Nizamut Adawlut (who had held position as court of reference at that time). Mouat was an early representative of the kind of medically trained officer who sought to change the operations of colonial governance in India well before the new imperialism of the twentieth century. Mouat was an instigator of prison reform and education reform, particularly medical education of natives, and is unusual in having held both the roles of Inspector-General of Hospitals and Inspector-General of Gaols in Lower Bengal.³³⁴ Mouat's ability to traverse the divide between medical and judicial spheres in India translated into his desire to see Chevers publish his text on medical jurisprudence. In the 1860s, the Government of India did not demonstrate a great deal of concern about the status of psychiatric knowledge, and Mouat's insistence on Chevers' publishing would have been quite unusual.

Chevers obtained nine years of reports, and summarized his findings in an elaborate paper in the *Indian Annals of Medical Science* for October 1854, which attracted the attention of the Marquis of Dalhousie, who requested that Chevers publish the report separately. In 1856, the second edition of the work appeared; the original treatise was "almost entirely rewritten", but only 500 copies were issued, and the Government distributed 400 of these among district magistrates and judges. The work was thus never "published in the usual sense of the term"³³⁵, and was difficult to obtain outside of the legal field. An 1870 publication, *A Manual of Medical Jurisprudence for India*, was produced as a more accessible edition of Chevers' paper.³³⁶

³³⁴ Lawrenson, "Frederic John Mouat," 201-205.

³³⁵ Norman Chevers, *A Manual of Medical Jurisprudence*, ix.

³³⁶ *Ibid.*

The production of a text on jurisprudence, concerning lunacy (among other issues), in the legal field is representative of the complex relationship between medicine and law in matters of insanity. Chevers's career in India echoed this complexity: he had been Surgeon-Major in the Bengal Army, Principal of the Calcutta Medical College, and President of the Bengal Social Science Association, who was called as an expert witness in many cases of medical jurisprudence, but he was never placed in charge of a lunatic asylum, despite his education and knowledge of moral treatment.

The story of Chevers publishing his text is illustrative of the unsteady position native lunacy held within the existing public service infrastructure that the colonial government had established in India. Chevers, Mouat, and many other medical men continued to be invited by the legal profession to provide their opinions on insanity, but judicial concerns for public disorder regularly usurped their medical expertise. The problem was that the court could only charge criminals if they were accountable for their actions, but reformist Victorian attitudes towards insanity (as manifest in men like Chevers) argued that native lunatics could not be held to the same standards. There was constant negotiation between the two forms of expert knowledge, and medico-legal conflict at the administrative level or in the courts translated into ambiguity or confusion on the ground.

Discrepancy between departments also manifest itself in the interaction between asylum superintendents and other state officials. Superintendents would correspond with the Judicial Department as much as, if not more so, they exchanged official correspondence with the Medical Department: notes were sent to officers' secretaries, requesting permission to move one patient to another asylum, or to inquire under whose

authority extra staff could be hired. Information about the asylum's daily functioning, for example the numbers of admissions and cures as found in the asylums' Annual Reports, were sent to the Medical Department. In this way, patients, staff and asylum commodities were equally discussed with the Medical and Judicial departments, with few hard-and-fast rules as to which department had greater or superior authority.

For example, in 1871, Major-General C. A. Barwell, the Chief Commissioner of the Andaman and Nicobar Islands, sent a note to the Judicial branch of the Home Department, requesting that they cease their practice of sending insane prisoners to Port Blair, where he was stationed.³³⁷ In December 1871, the Home Department wrote to the Superintendent at the Madras Lunatic Asylum, concerned that his staff were encouraging the practice of off-loading insane prisoners to the Islands instead of treating them in Madras.³³⁸ By April 1872, several letters had been exchanged with regards to the status of insane prisoners in the Madras Presidency: were they to be committed to an asylum as insane, or to a jail as criminal, and what ought they to do with prisoners in the Port Blair penal colony who subsequently went insane?³³⁹

Much of these administrative issues were resolved as the Government reorganized its bureaucratic departments to reflect the changing nature of their colony. Amidst this reorganization, Dr. Chevers retired from India, and never saw the success of his text in *Medical Jurisprudence*. Chevers represented a particular kind of medical expertise that was sought in India at the time, however, being unable to traverse the divide between

³³⁷ Deputation of insane prisoners to Port Blair, August 1871, Port Blair, Home Department, NAI.

³³⁸ Deputation of insane prisoners to Port Blair prohibited, December 1871, Judicial B, Home Department, NAI.

³³⁹ Convicts being returned to India, April 1872, Port Blair, Home Department, NAI; Establishing a lunatic asylum in Port Blair, March 1872, Medical A, Home Department.

medical and judicial spheres (like Mouat) was unable to intervene in the management of native insanity. Ultimately, as the short anecdote above shows, the difficulty Chevers experienced in his publication was reflected in the administration. The following section reveals how the government became more invested in lunacy legislation as the century progressed.

Administrative Change

In September 1873, native asylums were officially assigned to the Medical Branch of the Home Department. Prior to this date, they had existed unsuccessfully under the care of a variety of British offices, including the Medical Department, the Judicial Branch, the ICS, etc., but never with any official capacity. The European asylums had long been funded by the Military Department, and by extension some of the early native asylums had received some of this funding. However, the “birth of the native asylum” in 1858 did not arise out of any single government office, and several historians of Indian psychiatry have overlooked this. The previous section underlined the uncertainty inherent to the lack of official ‘home’ at the administrative level. The change in authority in 1873, from an unassigned colonial structure to a medical institution, had several repercussions. This section will examine the administrative changes that permitted the assignment of lunatic asylums to the Medical Department, highlighting again existing vulnerability or lack of stability in the administration, before nodding to some of the repercussions and their importance in the history of psychiatry and the history of South Asia.

Administrative work relating to the Lunatic Asylums was originally assigned to the Public Branch of the home Department. In September 1873, this work was transferred to the newly created Medical Branch under that Department. The 1858 Government of

India Act had changed the structure of the governing of India, including the way medical, judicial and other matters were organized. On 25 January 1858, the medical boards of each of the three presidencies were abolished and the roles were reassigned to an officer of each presidency, who was appointed “Director-General of Medical Department”.³⁴⁰ By 1 April 1896, the Bengal, Madras and Bombay medical services had been centralized into the Indian Medical Service, whose head was designated Director-General of the Indian Medical Service. He remained under the administrative control of the Home Department until 1918, when control was transferred to the Education Department. As a result, the records of the Hospital Board, the Medical Board and Lunatic Asylums are preserved in the National Archives under the Home Department.³⁴¹

The Judicial Branch of the government managed civil and criminal administration, as well as matters relating to the police and penitentiary system. In 1860, many of the matters relating to the police and jails were under the Foreign Department, but this control was transferred to the Home Department with the enactment of the Indian Penal Code. Within five years, all judicial business of the British Non-Regulation Provinces and the Princely States (such as Mysore and the Hyderabad Assigned Districts) was also transferred to the Home Department.³⁴² As any business relating to the

³⁴⁰ Medical Board Proceedings, 25 January 1858, NAI. See also, N. Jayapalan, *Indian Administration* (New Delhi: Atlantic Publishers, 2001), 38.

³⁴¹ This is something of an anachronism – in the nineteenth century, the records of the lunatic asylums were more likely to be collected with the judicial/legal records than they were with the medical records, especially due to the high number of criminal lunatics being transferred between prisons and asylums. Only the asylum reports for Bengal were grouped with other medical records, due to the fact that they were often written by superintendents whose duties towards medical institutions meant the reports formed part of a general collection, entitled *General Report on the Lunatic Asylums, Vaccination and Dispensaries in the Bengal Presidency 1868*. See “Guide to the Archives,” National Archives of India, New Delhi, 47.

³⁴² Foreign (General), ‘B’, May 1867, No. 75, NAI.

Cantonments was also transferred to the Home Department in 1867, it was decided to also separate work relating to Jails into an independent Jails branch. By May 1888, the Jails Branch dealt with all administration in the penitentiary system, and also any work relating to foreign missionary activity in India.³⁴³ The creation of a separate Jails Branch at approximately the same time as the transfer of the lunatic asylums to the Medical Branch of the Home Department is important.³⁴⁴ It suggests that the growing attitude towards insanity as a medical issue was occurring in parallel to the desire to rigorously delineate the punitive measures inherent to the colonial prison. Expectations for officers recruited to either institution (the native prison or the native asylum) were similarly codified.

Mark Harrison has written about the dual system of employing natives and Europeans to medical service in Bengal, and the different yet complementary expectations of both groups of actors. The East India Company began recruiting Indians as “compounders, dressers and apothecaries” early in the eighteenth century, but only in the 1760s were these assistants organized officially into a Subordinate Medical Service (SMS).³⁴⁵ With the founding of Calcutta Medical College in 1835, military and civil surgeons and assistants were required to train for two years and apprentice at a recognised medical institution. This encouraged an increase in the number of applicants to the SMS, and by 1880, after the transfer of lunatic asylums to the medical department,

³⁴³ “Guide to the Archives,” 93.

³⁴⁴ A separate Jails Branch was created in 1868, and Lunatic Asylums were officially assigned to the Medical Branch in 1873. Governmental discussions about both administrative changes overlapped in time, and often content.

³⁴⁵ This occurred first in Bengal, with the other presidencies following suit in the early nineteenth century. Mark Harrison, *Public Health and India*, 7.

meant that an increasing number of natives were entering the asylums as Western-trained employees.³⁴⁶ The *Medical Times and Gazette* wrote of this transfer as follows:

Medical Parliamentary Affairs – In the House of Commons, on Thursday, February 26, in reply to an inquiry by Dr. Playfair, the Secretary of State for War said it had been decided to abolish the double system of medical administration on the staff in India, and from March 31, 1880, the British Medical Department and the Indian Medical Department will be understood as one department for the medical administration of the army in the three presidencies; the Surgeon-General at headquarters in each presidency being always an officer of the British Army Medical Department. This change will necessitate the retirement of six Deputy Surgeons-General of India, as they will be in excess of the requirements according to the new regulations, and the Government of India offers to each a retiring allowance with an extra pension and a step in rank.³⁴⁷

With administrative change came changes in rank, appearance and status. The lunatic asylum was officially a medical institution and thus acquired the status becoming of a colonial hospital. Asylum superintendents, too, were imbued with a different status: they were suddenly part of the lengthy history of medical officers in colonial India. Instead of representing their local environment, the asylum, superintendents self-identified with a much larger and more professional group of actors in colonial India. Lunacy became a medical issue, while penal institutions and Inspector-Generals of Prisons gradually lost their authority over how to manage and locate the psychologically deviant native. As Roger Smith has argued, codes and Acts are often symptoms, rather than causes, of fundamental shifts towards insanity.³⁴⁸ In this case, the shift in administration led to a lunacy amendment in 1889, whereby native lunacy could only be managed in asylums.³⁴⁹

³⁴⁶ The effect of Western medical training on the kinds of Indian actors entering the asylum will be discussed at length in the next chapter.

³⁴⁷ *The Medical Times and Gazette* (London: J&A Churchill, 1909), 267-271.

³⁴⁸ Roger Smith, *Trial By Medicine*, 12.

³⁴⁹ Act IV of 1889, The Lunacy Amendment Act, NAI.

By the end of the nineteenth century, then, the government had made several interventions into the asylum, lunacy legislation and the management of colonial psychiatry. By the turn of the twentieth century, the colonial asylum in India looked very different from its previous incarnation here.

The Indian Lunacy Manual – 1909

Major R. Bryson was an officer for the Indian Medical Service, who was employed as Principal of the Medical College at Madras and as Senior Medical Officer of the General Hospital.³⁵⁰ Having been superintendent of the Calicut Asylum on the southwestern coast for two years, he mysteriously took leave from the IMS for nine months, only to return and publish one of the most widely read lunacy texts in India at the time.³⁵¹ Major R. Bryson's *The Indian Lunacy Manual* was published in Madras in 1909 "to place within handy reach of all Medical Officers a Summary of the Rules and Regulations referring to lunatics."³⁵² The *British Medical Journal* criticized the first edition for focusing only on the Madras Presidency and suggested that "with some alterations and additions, it might be made applicable to other parts of the Indian Empire."³⁵³ The *Indian Medical Gazette* also critiqued the Manual for being "not as a rule available to District Officers when called upon in an emergency", and encouraged Bryson to produce a version that could be distributed to District Officers and the public

³⁵⁰ India List and India Office List, 1905, 83-87, BL.

³⁵¹ Indian Medical Gazette, Volume 40, 1905: 159, BL; *Annual Report on the Insane Asylums for the Madras Presidency*, 1900, 1901 and 1902, 55, NAI.

³⁵² Bryson, *The Indian Lunacy Manual*, 1908.

³⁵³ *BMJ*, "Notes on Books," July 31, 1909: 271, BL.

alike.³⁵⁴ The second edition was published only a year later, in March 1910, “in response to the appreciation, by the general public, of the intention of the compiler to supply a handbook of information in aid of those who have a relative afflicted with insanity sufficiently pronounced to require admission into an asylum.”³⁵⁵

³⁵⁴ *Indian Medical Gazette*, February 1909, NAI.

³⁵⁵ Bryson, “Preface to Second Edition,” *Indian Lunacy Manual*, 1910.

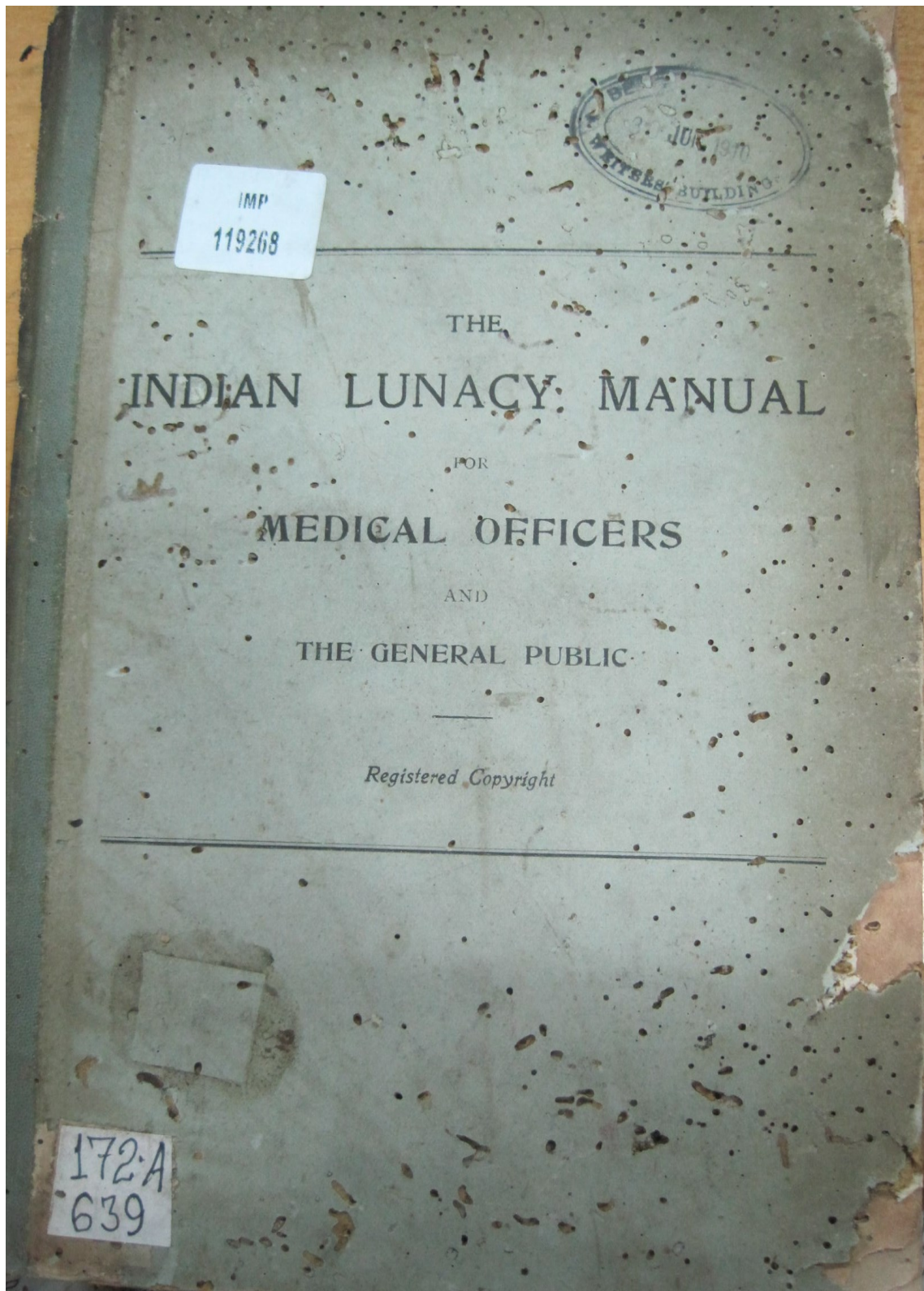


Figure 1: A worn copy of Bryson's *Indian Lunacy Manual*.

Bryson was not considered exceptional in his practice of asylum medicine. Rather it was his organization and his ability to extract information from the complicated history of India's lunacy legislation that was lauded, by contemporary medical journals and his peers alike. He included all the certificates and forms that needed completion for admission, diagnosis, treatment and release of a patient.

14

FORM B.
Order for the Reception of a Private Patient (See Section VII
of Act XXXVI of 1858).

I, the undersigned, hereby request you to receive.....
a lunatic (or an idiot, or a person of unsound mind), as a patient into your asylum.
Subjoined is a statement respecting the said.....
(Signed) Name.....
Occupation (if any).....
Place of abode.....
Degree of relationship (if any), or other circumstance of connection with the patient.....
Dated this..... day of 19.....

To
THE SUPERINTENDENT, LUNATIC ASYLUM AT.....

STATEMENT.

[If any of the particulars in this Statement be not known, the fact to be so stated.]

Name of the patient, with Christian name at length.....
Sex and age.....
Married, single or widowed.....
Condition of life, and previous occupation (if any).....
The religious persuasion, as far as known.....
Previous place of abode.....
Whether first attack.....
Age (if known) on first attack.....
When and where previously under care and treatment.....
Duration of existing attack.....
Supposed cause.....
Whether subject to epilepsy.....
Whether suicidal.....
Whether dangerous to others.....
Whether found lunatic by inquisition or enquiry under order of Court, and date of
Commission or order for inquisition or enquiry.....
Whether any member of patient's family has been or is affected with insanity.....
(Signed) Name.....

(Where the person signing the statement is not the person who signs the order,
the following particulars concerning the person signing the statement are to
be added, namely):—

Occupation (if any).....
Place of abode.....
Degree of relationship (if any), or other circumstances of connection with the patient.....

N.B.—These two Forms, A & B, are authorized in the Schedule to Act XXXVI of 1858.

Figure 2: Order for the Reception of a Private Patient, *Lunacy Manual*, p. 14.

As Figure 3 shows, Bryson included information for treatment of private individuals, and not simply state-funded patients. He gave special mention to those “insanes of European parentage”, but in general his Manual considers native and European patients under the same rubric.³⁵⁶ Consolidating the admissions processes for private, public, native and European patients demonstrates a shift in expectations for the asylum: it was no longer reliant upon just the admission of local or involuntary patients, but of fee-paying voluntary patients too. In fact, the asylum was also a place that could expect patients to pay, as compared to the nineteenth century native asylum, where such an idea would have been an anathema. There was also a growing sense that lunacy was a universal condition, affecting Europeans and natives alike in India. Consolidation of their treatment preempted the second set of lunacy laws, which will be discussed in the next chapter, whose enactment would enforce the changes already made by Bryson and his peers.

Major Bryson himself was representative of a new breed of medical officer in the colonial asylum. He was well-versed in modern medicine, having taught at several Medical Colleges in the Madras Presidency, and published an original monograph on sanitation in the Nilgiri Sanitaria soon after completion of the Lunacy Manual.³⁵⁷ His work was so influential, a Bryson Clinical School was opened, attached to the Stanley Medical College of Madras, by Governor Lord Willingdon in 1924 after Bryson’s death.³⁵⁸

³⁵⁶ *Ibid.*

³⁵⁷ Robert Bryson, *Nilgiri Sanitaria* (Nilgiris, 1916).

³⁵⁸ Bryson is quoted as saying “If the foundations had not begun then, and if the building had not been pressed at a feverish pace during 1914, the Great War would have considerably hammered the whole project [of building a hospital]. If it had not been for the students of the old bullet factory, I am pretty

By 1909, then, a British officer like Bryson could publish a Manual containing recent lunacy legislation, medical certificates for admission and diagnosis, and a rubric that considered the European and native lunatic alike. This was markedly different from the circumstances in which Norman Chevers published a text on lunacy and medical jurisprudence forty years prior. Not only were Chevers and Bryson very different kinds of medical men, but, as this chapter has shown, there were an increasing number of interventions made by the British government in the interim to secure psychiatry as an effective tool of colonialism. Psychiatry had become a more formidable and reputable profession, with governmental infrastructure to support it. The inchoate asylums network of the nineteenth century could not exist in this new environment.

There was no single point of rupture or event that transformed the government's shift in priorities with regards to lunacy at the end of the nineteenth century, but there were several contributing factors. Enforcing the IPC made it easier to delineate what was criminal, and what was the realm of insanity. The management of lunacy, whether in the courtroom, the native asylum, or on the bookshelf, reflected the investment of the colonial government in the utility of psychiatry and lunacy for its own goals. In the middle of the nineteenth century, lunacy had an ambiguous role in the colonial administration of India, partly because of the disorganization inherent to the creation of a new system of government after 1857, and partly because of the desire by this new bumbling government to provide social services without considering their use in the long-term. The ambiguity of colonial rule in the middle of the nineteenth century translated

certain that nothing like the present Royapuram Hospital [now the Stanley Medical College] could ever have come into existence!" *Guidebook for Stanley Medical College* (Chennai, 1963), NL.

down to the daily practice of the asylum: as we saw in earlier chapters, this ambiguity manifested in an extraordinarily hybridized and permeable space. Asylums operated at a locally-variable fashion, responding to social structures at a local level, because they were the only frameworks available for asylum superintendents to use. Asylums thus only tenuously responded to the official structures above, be they medical, judicial or another part of the bureaucratic machinery. With a more efficient organization of the colonial administration, however, there were effective and enforceable frameworks being offered to superintendents in their asylums. Simultaneously, there were disciplinary frameworks that reified the role of an asylum superintendent, and provided a platform for psychiatric expertise in the colonial world.

A simple conclusion is that lunacy in British India had different significance to lunacy in Britain. This conclusion is useful because it counters the claims of the British government, which had done its best to suggest British India could and should be run according to Britishized laws and legislation, that the East India Company had squandered its authority precisely by running the subcontinent according to local, hybridized or Indian norms. Appreciating that lunacy had a different valence in India allows us to challenge the C19 form of colonial governance, that British, “civilized” or “enlightened” norms were the only way to control India and the “uncivilized” world. Appeals to local knowledge hadn’t worked for the EIC (too much hybridity and loss of British authority), but there were ways to appeal to local knowledge to subordinate it.

The change in administrative organization, in management of the asylum, and in the role of the superintendent, all show a very different institutional genealogy in India when compared to the history of the colonial prison and the colonial hospital. Far from

being an archetype of colonial power, the colonial asylum of mid-century India presents us with a very different institutional space, which was malleable and directed by whichever social, cultural and political trope had the most valence. This is still an argument for power, but a very different kind of power from the narratives usually written about colonial institutions. Colonial prisons and hospitals alike were directed by strong administrative and ideological doctrines in India: prisons could punish and reform the subject, while hospitals could survey and control the body. There were clear reasons why prisons and hospitals were necessary for British rule of India. Native asylums, by contrast, did not initially have a clear role to perform for the British government; they neither worked to discipline their subjects nor did they present the British as particularly effective or magnanimous rulers. This chapter showed how the asylum gained a role, through internal movements in the subcontinent: macro-administrative change, attempts to converge or delineate medical and judicial spheres, and the publication of a new genre of lunacy text. The next chapter will speak to these movements and locate them in the wider context of the Empire to show how the once-hybrid and permeable lunatic asylum was transformed.

Chapter 5: 1912: New Legislation for a New British India

In April 1910, the Officiating Judicial Secretary to the Government of Eastern Bengal and Assam wrote to the Secretary to the Government of India with regards to the lunatic asylum in Dacca. The previous five years of asylum reports had shown Dacca Asylum to have a high mortality rate and the Government was now concerned with the use of the building as a psychiatric establishment. “The present site of the Dacca asylum is unsanitary,” Ralph Hughes-Buller wrote. “The Government’s suggestion is... that an entirely new asylum be built.” The site was no longer suitable for an asylum, but Hughes-Buller believed it could be “conveniently utilized for the extension of the Dacca Central Jail.”³⁵⁹ A belief in the psychiatric management of the insane meant that older asylums, like the one at Dacca, would have to be replaced with newer, “scientific” institutions. Over the next three months, Hughes-Buller and other administrators argued that Indian insanes required a better site “in consideration of their healthiness, accessibility and economic conditions”, and a plan emerged for “a new Central Lunatic Asylum for Indian Insanes at Ranchi.”³⁶⁰

³⁵⁹ *Question whether the Dacca lunatic asylum should be converted into a Central Asylum for the province of Eastern Bengal and Assam.* April 1910, Nos. 111-112, Medical B, Home Department, NAI.

³⁶⁰ *Project for the construction of a new Central Lunatic Asylum for Indian Insanes at Ranchi.* May 1910, No. 4, Medical A, Home Department, NAI; *Proposed closing of the present Dacca lunatic asylum and construction of a central asylum for Eastern Bengal and Assam,* July 1910, Nos. 111-112, Medical A, Home Department, NAI.



Figure 3: Block plan for Ranchi Lunatic Asylum. This plan has been preserved and displayed by the Central Institute of Psychiatry. 1922.



Figure 4: Ranchi was transformed from a lunatic asylum to an institute for psychiatric research in the twentieth century. 2011.

The hope for a “scientific” institution came from the ascension of professional psychiatry over the preceding decade and the administrative need for medical, rather than punitive, practices in the asylum. For instance, in planning to close the old Dacca asylum and establish a new institution at Ranchi, the Government of India secured “the services of Captain W. C. H. Forster, Professor of Pathology at the Lahore Medical College” to assess the etiology of patients’ medical health and ensure a suitable site was chosen.³⁶¹ Medical education in particular had created an entirely new population of Western-trained Indian medical staff that populated the asylum. The desire to physically erase the institutions associated with the old asylum practices, and construct new institutions

³⁶¹ *Question of closing the present Dacca asylum*, June 1910, Nos. 102-110, Medical A, Home Department, NAI.

without those associations, was a marked difference in attitude towards the care and treatment of native lunacy.

By the second decade of the twentieth century, the walls of the native lunatic asylum were figuratively and literally less permeable. After struggling to juggle the responsibility for native lunacy between medical and judicial branches of government, the early twentieth century was a time for directed treatment of insanity in specialized colonial institutions. The passing of Act IV of 1912, “An Act to consolidate and amend the law relating to Lunacy,” was not the start of a change in the native asylums of India, but a manifestation of change already underway.³⁶² The title of the act is the most explicit evidence of this change. Unlike the hesitant attempts of the Lunacy Acts in 1858 to establish pan-Indian curative and therapeutic spaces to house and help native insanes, the 1912 Lunacy Act was representative of a more efficient and assertive state attitude to consolidate the management of lunatic asylums in the subcontinent.³⁶³ In many ways, the 1858 native asylum had been an experiment: the first India-wide attempt to assess, evaluate, count, treat and manage native insanity. There had been space, on the ground and in the bureaucratic spaces of the metropole, for local beliefs to enter, and for a wide range of actors to cross the asylum walls. At the same time, an ‘experiment’ suggests that the government had been complicit in testing and directing the establishment of this institution, and this was simply not the case. Earlier chapters have shown that the legislation governing the colonial asylum of the nineteenth century had more to do with asylum and pauper reforms in England than with a conscientious administration.

³⁶² Indian Lunacy Act of 1912, NL.

³⁶³ One could argue that the 1858 acts were much more engaged with how asylums *could* function.

Similarly, a multitude of practices that entered the asylum were present precisely because of an absence of governmental directive. By 1912, the ability for so many different actors and ideas to enter the asylum had gone. By 1912, there was no confusion as to what was the purpose of a native asylum under the Raj. Native lunatic asylums had been transformed into institutions that clearly participated in the larger goals of colonial surveillance, discipline and social control.

What explains this overarching change in asylum management and governing mentality? There are three main reasons. Firstly, psychiatry had been subsumed by mainstream medicine as a well-delineated and respected profession. In the late nineteenth century, European psychiatry benefited greatly from the popularity and effectiveness of Emil Kraepelin's diagnostic categories. The respect for psychiatry and psychiatric knowledge in Europe translated into higher wages and increased demand for asylum superintendents in India. The influence of Kraepelin and other nineteenth-century psychiatrists can be seen in the naming of the wards at Ranchi Lunatic Asylum (Figures 4 and 5). This professionalization of psychiatry has been well-documented by historians of medicine.³⁶⁴

³⁶⁴ Most of this work on psychiatric professionalisation has occurred with a European focus. For Germany, see Eric J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca: Cornell University Press, 2003). For France, see Jan E. Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Cambridge; New York: Cambridge University Press, 1987).



Figure 5: Ward names after Emil Kraepelin in the Central Institute of Psychiatry, Kanke (formerly the Ranchi Lunatic Asylum). 2011.



Figure 6: Ward named after John Conolly in the Central Institute of Psychiatry, Kanke. 2011.

A second reason was the rise of medical education in India, which created an entirely novel population of Western-trained Indian doctors and superintendents to inhabit the asylum. After multiple education reforms in the nineteenth century, an increasing number of Indians were completing higher education in Britain and at home, and medical education was key to Indians' climbing the imperial ladder. The Indian Medical Service (IMS) and Subordinate Medical Service (SMS) were increasingly seen as viable opportunities to gain success in India. These Services placed emphasis on biomedical training, and mandated apprenticeships within colonial institutions like the hospital and the asylum. These IMS and SMS officers gradually replaced the ad hoc and local attendant population that had previously staffed the asylum. In this way, the colonial ideologies embraced in universities and other medical institutions were brought into the asylums.

Finally, the changing Empire beyond South Asian borders translated into changing purpose of asylums in British India. Where British India in the nineteenth century had been a 'laboratory of Empire', i.e. a prized colony that informed political and cultural developments elsewhere in the world, territorial expansion and asylum building in other colonies in the early twentieth century meant that India's insanes no longer formed the blueprint for colonial psychiatry. As I wrote in the previous chapter, this was not the same British India that had borne the first set of lunacy laws. This was an older colony, governed by an administration that had matured beyond the mid-nineteenth century Company-to-Crown transition, and was no longer scrambling for legislation from England. Moreover, India was no longer one of experimentation; it was a foundational cornerstone to the success of the empire. The establishment of colonial institutions in the

“dark continent” coincided with the need to build newer, “scientific” psychiatric institutions in India.³⁶⁵ This chapter will focus on the production of Indian medical staff and the effect of larger colonialism within the British Empire to demonstrate and argue for the collapse of the fluid nineteenth-century native asylum, and the rise of disciplined, rigorous and impervious psychiatric institutions in the twentieth century.

Act IV of 1912

On 18th September 1911, Charles Hardinge, the 1st Baron Hardinge of Penshurst, presided over a meeting with the Council of the Governor-General of India in the Viceregal Lodge of Simla. This was only three months before the Delhi Durbar, whose organization was still underway.³⁶⁶ Sir J. L. Jenkins is recorded as having introduced a Bill to consolidate and the existing lunacy laws in India, stating:

We propose to consolidate these enactments and to introduce certain amendments and especially to bring the law in certain important particulars into line with the modern English act.³⁶⁷

The “modern English act” to which he was referring was the English Lunacy Act of 1890, and its amendment by the English Lunacy Act of 1891. The legislative department of the Council was complimented for its painstaking labour in writing the Bill. For reasons unknown, the Council did not pass the Bill that year, but met again early in 1912

³⁶⁵ Candice Goucher et al., “The Tentacles of Empire: The New Imperialism and New Nationalism in Asia, Africa and the Americas,” in *idem.*, *In the Balance: Themes in Global History* (Boston: McGraw-Hill, 1998).

³⁶⁶ The Delhi Durbar had already occurred twice, the first time in 1877 and the second time in 1903. Each occasion had lasted between two and four weeks and involved lavish banquets, sporting events, exhibitions of Indian art, and very public homages by maharajs to the British monarch. These durbars were created to express imperial policies, and embodied a Victorian embracement of Indian life within British politics. Thomas Metcalf, *An Imperial Vision: Indian Architecture and Britain's Raj* (Berkeley: University of California Press, 1989), 44.

³⁶⁷ Jeffrey L. Jenkins, quoted in O. Somasundaram, “The Indian Lunacy Act, 1912: A Historical Background,” *Indian Journal of Psychiatry* 29, 1 (January 1987): 3-14.

to do so.³⁶⁸ On 10th January the Council met again, this time under the presidency of Sir Guy Fleetwood Wilson. Wilson reflected on the nature of the lunacy Bill in his diary:

I am afraid the necessity for the Bill has been made out. The sad part of the whole business is that the seditious and dangerous element is an infinitesimal fraction of the Indian people, but the misconduct looms large in the public mind, and there arises a tendency to forget the wholly admirable conduct of the population as a whole.

What has already struck me is the even temper and fairness with which the Indian members deal with what must be for them unpalatable legislation. It certainly is so to me, necessary though it be, and it threatens to march hand in hand with my financial anxieties [...]³⁶⁹

Sir Wilson was speaking of the Indian members on the Select Committee who read and passed the Bill. He was concerned that their ethnic and racial association with the Indian public would affect their decision, but clearly the Indian men on this Committee had internalized many of the same attitudes towards native insanity as had their British colleagues. Wilson may have been unusual in his empathy for the lunatics at the receiving end of this Bill, and the Indian Council members who participated in its passing. He acknowledged his own depression in his diary, and mentions several Indian acquaintances with affection.³⁷⁰

It is telling that five of the fourteen members of the Select Committee who passed the Bill were Indian. Mr. Syed Ali Imam, Moulvi Syed Shamsul Huda, Mr. Dadabhoi, Babu Bhupendra Nath Basu, and Mr. Mudholkar were all British-educated Indian men

³⁶⁸ I would argue that the organization of the impending Durbar took precedence, and that finalized discussion of the Lunacy Bill was postponed until the Durbar finished.

³⁶⁹ Guy Fleetwood Wilson, "Repressive Legislation," *Letters to nobody, 1908-1913* (London: John Murray, 1921), 11.

³⁷⁰ He foregrounds his own battles with mental health in the dedication to his diary: "Affectionately dedicated to my good friends, the Simla monkeys, whose entertaining companionship helped to stem many a wave of overwhelming depression, and who seemed to understand me as I think I understood them." Later he writes of the "greatest courtesy and very friendly consideration" he received from the Parsees of Bombay during a "bout of melancholy". Wilson, *Letters to nobody*, v, 77.

who had ascended the ranks of the British government, and were now responsible for legislation concerning Indian lunacy. This was very different from the case in 1858, where all of the legislators were British, and no Indians would have been deemed eligible to such status. How had local Indian men ascended to the ranks of legislative decision-making in the British Indian government? What was the ideological direction of this multiracial Select Committee? Did it represent an ideologically mixed administrative knowledge, akin to the “hybridized practices” of the nineteenth-century native lunatic asylum, or were Britons and Indians in this administration of the same mind?

The Committee began with a delineation of the areas that fell under this Act’s jurisdiction. Extending to “the whole of British India, including British Baluchistan, the Santhal Parganas, and the Pargana of Spiti”, the Act reflected the ever-changing geographical and political developments of British India.³⁷¹ They did not change the wording of the previous Acts a great deal. Instead, they wrote:

Nothing contained [herewith] shall be deemed to affect the powers of any High Court which is or hereafter may be established under the [...] Acts, 1861-1911, over any person found to be a lunatic by inquisition or over the property of such lunatic, or the rights of any person appointed by [the Indian High Court] as guardian of the person or manager of the estate of such lunatic.³⁷²

They were still concerned with the act of certification on admitting a patient, and exhibited great anxiety about the “improper confinement of any person in an asylum on a false allegation of lunacy.”³⁷³ The most significant change was the directive, or mission, behind the new Act, and the confidence with which they men presiding in the top

³⁷¹ Indian Lunacy Act, 1912, s. 1, NL.

³⁷² *Ibid.*, s. 2.

³⁷³ *Ibid.*, s. 4.

echelons of this colony would enforce this mission from above. After the medico-legal interactions of the preceding four decades, they were in an excellent position to delineate the processes by which judicial inquisitions into lunacy should occur. They made recommendations based on knowledge of an asylum system already in place, and their future potential for therapeutic treatment: “We regard this provision as one which is likely to be of considerable value.”³⁷⁴

Importantly, the Committee surveyed a variety of actors before submitting their final report on 28th February 1912. They sent letters to the Raja of Burdwan, the Chief Commissioners of Baluchistan, Coorg, Ajmer and the North Western Frontier Province, Secretaries to the Governments of the United Provinces, Burma, Punjab, Eastern Bengal and Assam, the Central Provinces, Bengal, Bombay and Madras, and members of the High Court of Calcutta. These men represented the apex of colonial power in their respective parts of the subcontinent. Consultation with these men was the first step to enforcing the new colonial directive for lunacy in India. Each of these esteemed men, half of whom were Indian, the other half British, wrote letters indicating their support of the Bill. Their signatures form a collective representation of the coherent Anglo-Indian position behind the treatment of lunacy in early twentieth-century India, a stance that was very different from the heterogeneous viewpoints that constructed lunacy legislation in the middle of the previous century.³⁷⁵

³⁷⁴ *Ibid.*, s. 33.

³⁷⁵ The signatures also make an analytically useful point of contrast, when compared with the names and titles of the men who responded to Sir Clark’s asylums survey in 1868. The signatures arrived more quickly in 1912 than the surveys were completed in 1868, partly because of improved communication links in this later period and partly because of the authority of the Select Committee.

Act IV of 1912 was passed on 16th March 1912, two weeks after the final draft was submitted to the Council. The Act itself did not take effect in every part of India simultaneously. The precipitation of new Indian states, with their own seats of governance, meant that the 1912 Lunacy Act was enacted slowly over the next decade. Partition of Bengal in 1905 had produced Eastern Bengal and Assam, which was revoked in 1912 when Assam and Bengal redistributed their territorial boundaries.³⁷⁶ Bihar and Orissa also separated from Bengal in 1912, while Delhi separated from Punjab as the new capital of British India.³⁷⁷ The Tamil Nadu/Madras Medical Registration Act of 1914 was one of many regionally specific Acts that incorporated the Lunacy Act within their tenets:

Except with the special sanction of the Provincial Government, no one other than a registered practitioner shall be competent to hold any appointment as physician, surgeon or other medical officer in any hospital, asylum, infirmary, dispensary or lying-in hospital not supported entirely by voluntary contributions or as Medical Officers of Health. This takes precedence over Act IV of 1912, pertaining to lunatic asylums.³⁷⁸

Similarly, the creation of Jammu and Kashmir in 1920 was rapidly followed by enactment of the Jammu and Kashmir Lunacy Act of 1920.³⁷⁹ As in 1858, the social and political climate of India in the second decade of the twentieth century was unsteady. The Partition of Bengal, the relocation of the Indian capital to Delhi, and the Minto-Morely Reforms were all points of internal conflict, but beyond India, the British were also

³⁷⁶ John R. McLane, "The Decision to Partition Bengal in 1905," *Indian Economic Social History Review* 2, 3 (1964): 221-237.

³⁷⁷ K. L. Sharma, "Jharkhand Movement in Bihar," *Economic and Political Weekly* 11 (10 January 1976): 37-43.

³⁷⁸ Madras Medical Registration Act, Act IV of 1914, section 4, part 2, NAI.

³⁷⁹ Along with the Prisoner's Act, the Poisons Act and the Court of Wards Act of 1920, NAI.

engaged with territorial disputes with the Russian Empire, navigating the new “dominion status” of their white colonies in Australia and New Zealand, and staking their claim in Africa.³⁸⁰ Unlike 1858, however, the treatment of Indian insanes was a priority for the colonial government, which directed the new legislation more carefully, and was conscious of the twentieth century rationale behind colonial psychiatry elsewhere in the British Empire.

By 1912, there were twenty institutions for ‘natives’ in British India, most of which had been established in the nineteenth century, but some of which were European asylums that had been converted to house ‘natives’ (e.g. Bhowanipore in Calcutta), and some were entirely new (e.g. the asylums in Bombay).³⁸¹ Within ten years, the terminology “lunatic asylum” was changed to “mental hospitals”; a clear indication of the professional and scientific rhetoric underlying psychiatry since the turn of the twentieth century.³⁸² The superintendents and assistants of most of these hospitals had increasingly Indian names: Singh, Varma, Murthy, Dhunjibhoy, Basu. These superintendents (soon renamed “Medical Directors”) were organized, having benefited from the professionalisation of psychiatry as a medical discipline, and also having received an English education. They wrote to each other and established journals. For example, the

³⁸⁰ Muriel Evelyn Chamberlain, *The Scramble for Africa* (New York: Longman, 2010).

³⁸¹ This was an increase in number of institutions, but still does not represent a “great confinement”. Of the total population of India (259,716,306, according to the Census of 1911), there was asylum accommodation for 7,243 people in India. Allowing for overcrowding in some institutions, this only represents 0.003%. Alexander W. Overbeck-Wright, *Mental Derangements in India, their symptoms and treatment: being a handbook to the theory and practice of mental disease in India together with notes dealing with the legal aspect of insanity and the various questions likely to arise concerning it* (Calcutta, and Simla: Thacker, Spink, 1921).

³⁸² Act IV of 1922, s. 1, NAI.

new mental hospital in Ranchi incorporated a research center, and medical students were encouraged to contribute to a special journal of medicine established in nearby Patna.³⁸³

The ability of colonial subjects to write back to the theories being espoused by nineteenth-century medical centres in Europe was important to the development of the lunatic asylum and psychiatric medicine in India. Shruti Kapila has written at length about the development of an Indian scientific elite, which engaged with and appropriated Sigmund Freud's work in the early decades of the twentieth century.³⁸⁴ Ranchi's medical students and the rest of the Indian elite learned from the European asylum medicine of the late nineteenth century and began a reflexive engagement with psychoanalysis and the new mind sciences of the twentieth century.³⁸⁵ How did these colonial subjects assume high-ranking roles in British Indian asylum medicine? The next section details the history of medical education in India, and argues that the newly-educated Indian elites gradually asserted control over the ecology of the asylum.

Medical Education and a New Population

The promotion of British education in India occurred early in the nineteenth century. The 1830s dispute between "Orientalists" and "Anglicists", over how the British government should push a pedagogic agenda, was the starting point for what scholars have called the "modernization" of Indian education systems.³⁸⁶ Victory went to the

³⁸³ Unfortunately there is only one copy of this journal series in existence, in a rather dilapidated state in the Medical Library at the Central Institute for Psychiatry in Ranchi. *The Patna Journal of Medicine*, Prince of Wales Medical College, 1933-1948, CIP.

³⁸⁴ Shruti Kapila, "Freud and His Indian Friends: Psychoanalysis, Religion, and Selfhood in Late Colonial India," in *Psychiatry and Empire*, ed. Megan Vaughan (Basingstoke: Palgrave Macmillan, 2007).

³⁸⁵ Kapila, "Freud and His Indian Friends," 130.

³⁸⁶ S.C. Ghosh, *The History of Education in Modern India, 1757-1998*, Orient Longman, 2000, p. 8.

Anglicists in 1835, with the publication of Thomas Babington Macaulay's "Minute on Indian Education".³⁸⁷ 1835 also saw the founding of Calcutta Medical College, which permitted Indians and some European soldiers to undergo a two-year course of instruction, culminating in an apprenticeship at a recognised medical institution.³⁸⁸ Asylums were not considered medical institutions until their administrative assimilation into the Medical Department of Government in 1873, but apprenticeships generally took place in medical hospitals.³⁸⁹ The 1835 rhetoric to "educate the people of India"³⁹⁰ was initially only concerned with the elite classes of native society, but a few years before Crown Rule, the British authorities encouraged the EIC to extend their provisions:

[T]he education which we desire to see extended in India is that which has for its object the diffusion of the improved arts, science, philosophy and literature of Europe; in short, European knowledge.³⁹¹

The reason behind this desire was the concern that "the systems of science and philosophy which form the learning of the East abound with grave errors."³⁹² The indoctrination of the Indian elites via British education was presented as an opportunity for the educated classes to ascend the corporate ladder of the Company. English language was first encouraged at the level of secondary education, but by 1857 there were

³⁸⁷ Macaulay, "Minute," 2.

³⁸⁸ Harrison, *Public Health in British India*, 7.

³⁸⁹ This assimilation was described in the previous chapter.

³⁹⁰ Charles Trevelyan, *On the Education of the People of India* (London: Longman, 1838).

³⁹¹ Despatch from the Court of Directors of the East India Company to the Governor General of India, 19 July 1854, section 7, reprinted in J. A. Richey (ed.), *Selections from Educational Records* (Delhi: National Archives of India, 1965), 366.

³⁹² *Ibid.*

universities in Calcutta, Bombay, and Madras, with Punjab and Allahabad soon to follow (in 1882 and 1887, respectively).³⁹³

Western-educated Indians worked to permeate the governing structures instead. Medical education was not primarily the means to achieve government employment, due to the low esteem in which the medical profession was held even in Victorian Britain in the early part of the nineteenth century. The role of the medical profession in India has been debated quite extensively by Mark Harrison and David Arnold, who suggest quite opposing views. On the one hand, Harrison suggests the colonial administration was indifferent to the utility of the medical profession for their imperial goals. Harrison argues that this was the case even after the Medical Registration Act of 1858.³⁹⁴ On the other hand, David Arnold argues for the “instrumentality” of disease and medicine in the colonial world.³⁹⁵ He suggests that the medical profession in India reflected the preoccupations and methods of British imperialism. In such an approach, this renders much of the Indian Medical Service and the Indian universities as simply end products of British opinion, which loses sight of the heterogeneity inherent to the population of Western-educated Indians, and the indeterminacy of social thought and action therein.

After transferring to Crown rule, the IMS became the responsibility of the British government in London, and surgeons, apothecaries, assistants and doctors attained higher wages and an increase in prestige. Public health work was especially rewarded: the 1864

³⁹³ By 1929, thirteen further universities had been established. Sanjay Seth, *Subject Lessons: The Western Education of Colonial India* (London; Durham, NC: Duke University Press, 2007), 2.

³⁹⁴ Harrison, *Public Health in British India*, 9-10.

³⁹⁵ Interestingly, Arnold disagrees with the idea of medicine as a “tool” for empire, even though this distaste is at odds with his commitment to medicine being an “instrument”. Arnold, “Introduction”, in *Imperial Medicine and Indigenous Societies* (New York: Manchester University Press, 1989), 2.

Military Cantonments Acts encouraged hygiene beyond military stations, as an indication of the concern that the health of the natives could affect the health of Britons in India. Public health work was also open to Indians beyond the IMS, and a variety of subordinate Indian staff [*bhisties*] swept the streets and disposed of night soil under a patchwork of sanitary legislation modeled on the British context.

However, there was also a concern that with increasing numbers of Indians joining the IMS, the status of the service was lower. As early as 1868, the *Lancet* included an article warning the government as to the status of medical officers in India:

It is of the first importance to the maintenance of imperial interests in the East [...] that everything in the life of a soldier, physical, social, moral and military, be thoroughly examined and ascertained [...] The Indian constitution is, like the Indian climate, deleterious to these [...] interests. Many questions require to be determined [and] a skilled medical education alone fits a man to answer [...] On whom should the Government rely if not upon its men? [...] the Indian is no substitute.³⁹⁶

The concern was born out of the fact that the IMS had opened up to Indians in 1855, even though, few Indians could join the service as the examinations were held in Britain. British newspapers reported that Indians did not have to attain as thorough a professional training to pass the exam. In India, the Indian Medical Gazette called for the standardization of examinations to the subordinate medical service (SMS), to ensure that the “dignity of their diploma” would be ensured.

Tired of this incessant back-and-forth over the role and status of education in India, especially that of medical education and qualification into government positions, Lord Curzon began an administrative movement to reform and regulate the universities in the colony. In September 1901, Curzon invited representatives of all extant universities to

³⁹⁶ “Medicine in India,” *The Lancet* 11 January 1868: 52-54.

a conference in Simla, in which he surveyed the whole field of education. He later gave a speech at Calcutta University, where he said:

The great fault of education as pursued in this country is, as we all now, that knowledge is cultivated by the memory instead of the mind, and that aids to the memory are mistaken for implements of the mind.³⁹⁷

However, the English-educated comprised less than 1 percent of the population, as the system of education was ultimately top-heavy, with a disproportionate emphasis on colleges and universities and, by extension, the classes of Indians who could afford to attend either. As Lord Curzon himself admitted, only twenty percent of boys eligible to attend the first four years of elementary school were enrolled in any sort of educational institution by 1900.³⁹⁸

A commission was appointed, under Thomas Raleigh, to enquire into the condition and prospects of all universities in India, and the Indian Universities Act was subsequently passed in 1904. The primary focus of the Act was to improve the education system, and prevent continued debate over the eligibility of Indian graduates for roles in government and positions of prestige.³⁹⁹ Gopal Krishna Gokhale, one of the senior leaders of the Indian National Congress, criticized the bill as a “retrograde measure” that cast unmerited aspersions on Indians in education and was designed to perpetuate “the narrow, bigoted and inexpensive rule of experts.” He founded the Servants of India

³⁹⁷ *Lord Curzon in India: Being a Selection from His Speeches as Viceroy and Governor-General of India, 1898-1905* (London: Macmillan, 1906), 485.

³⁹⁸ *Lord Curzon in India*, 331.

³⁹⁹ Philip Altbach, “Problems of University Reform in India,” *Comparative Education Review*, 16 (2): 251-266.

Society (SIS) in 1905 as a retort, to provide the kind of education and political traction he believed Lord Curzon, the ICS and the IMS failed to offer.⁴⁰⁰

The consequences of this reform and the ongoing struggle by Indians to attain government positions were threefold: firstly, there was a large population of British-educated Indians who were eager for employment (even in less prestigious institutions like the asylum); secondly, the role of the expert and the value of certain kinds of knowledge were being introduced to the educated and uneducated classes; and thirdly, the concern with Indian or British authority over this knowledge had sown the seeds of nationalist discontent.

With the rise of so many Indian intellectuals to positions in government, there was a need to train younger generations of Indian subjects to follow suit. The government had lost momentum with its concern for the pathological Indian mind, but had found a more effective way to train the Indian mind through education. Carla Yanni's monograph speaks to parallel work done by state institutions. Educational institutions could act in parallel with psychiatric institutions: the latter seeks a rehabilitative course to restore pathology to health, while the former seeks to refine and improve the mental capacity of its subjects. Yanni writes: "Asylums and colleges were similar in that they projected a civic image through their architecture; the two types often housed large numbers of people in a single structure [...] Colleges and asylums transformed the minds of their residents."⁴⁰¹ This was the case in India, where state-funded education and asylum

⁴⁰⁰ In his preamble to the SIS constitution, he wrote of his hopes that "The Servants of India Society will train men prepared to devote their lives to the cause of country in a religious spirit, and will seek to promote, by all constitutional means, the national interests of the Indian people." Quoted in Stanley Wolpert, *Gokhale: Revolution and Reform in the Making of Modern India* (Berkeley: University of California Press, 1962), 158-160.

⁴⁰¹ Yanni, *Architecture of Madness*, 95.

reforms were most effective when they worked together. As the number of both kinds of institution increased, so the government could reap the benefits of one – Western-trained Indian students – to discipline the other – psychiatric practice in the asylum.

Why did the universities and colleges engender so much more attention from the government than asylums? Funding was an issue. Over the previous four decades, the lunatic asylum network had cost the colonial government a great deal, with little recourse for reimbursement from the treated population. This was in stark contrast with the university and college network, which had produced colonial subjects who provided arguably more valuable services (administrative, bureaucratic, transport, etc.) than the asylum. At best, the native asylum came close to self-sufficiency, producing enough cloth and food for its inhabitants, and encouraging the attendants and patients to repair the physical structure when needed, but these institutions had little contributions to the Empire-building aspirations of the colonial government.⁴⁰² As a cornerstone of the British presence in the subcontinent, there was more to be gained by improving educational institutions than psychiatric ones.

By focusing on the education system, too, the Government begot an increasing number of medically trained Indians who were eager to attain government employment wherever there was an opportunity. There was no need to recruit untrained attendants and assistants from the local community: one could simply recruit university students who desired to complete their apprenticeship at the asylum. These Indian students were essentially unpaid, seemed familiar to the communities who lived and worked in the

⁴⁰² Some asylums produced sufficient crops to sell to the local community, and this was an extra source of cash, which offset the expenses of each staff's salary, recovering the health of incoming admissions and the cost of extra medications.

asylum, and overlapped a great deal with their British superiors when it came to intellectual pursuits. These Western-trained Indian men were familiar with the tenets of Western psychiatry and gradually ascended the ranks of the asylum staff to endorse a very European style of asylum management. Not only did these Western-educated Indian subjects look to the asylum superintendents for guidance (whereas superintendents had looked to their nearby communities in the previous incarnation of the asylums), but also they were also less likely to put forward alternative, local or non-Western ideas about insanity. In many ways, the Indian staff now inhabiting the native lunatic asylum was different from their colonial supervisors only in skin colour, and they propagated the same paradigms of psychiatric care and treatment as these men.

The success of university education reform in India permitted a new generation of Indians to enter the colonial asylum and convey with them a stronger sense of the colonial mission within. There was a close relationship between educational reform, medical goals and institutional imagination. Of course, chai wallahs still existed – the Western-educated asylum staff still drank tea – and we do not have the data to examine whether Indian patients were more receptive to Western ideas of psychiatry when conveyed through the mouths of their racial own. However, the presence of this new group of actors usurped the native attendants who had previously permitted a hybridized practice of asylum care within the walls of the insane asylum, and this reinforced the presence of British paradigms of insanity even further.

A Twentieth-Century Empire

It was only natural that these changes would be felt in the asylums. Many of the original asylums from the 1850s and 1860s had either closed or been rebuilt. Their layout and architecture began to reflect the asylums in Europe to a much greater degree.

Figure 7: Block plan of Rangoon Lunatic Asylum, Burma, showing sanctioned extensions to the building. 1897.

⁴⁰³ Gilmartin, "Scientific Empire and Imperial Science," 1994. See also Gyan Prakash, *Another Reason: Science and the imagination of modern India* (Princeton: Princeton University Press, 1999).

rationale for conquest over irrational people. This section details the ways in which larger imperial movements informed the tenor of the lunatic asylum in India.

As the previous chapter argued, British India was different from Britain. The same ideas inherent to British asylums could not be implemented directly to native asylums in India. This chapter will also argue that this was a different British India: the colonial state looked very different in the twentieth century when compared to its precedent in the middle of the nineteenth century. It was the same administration, but the infrastructure and the ideologies pertinent to colonizer and colonized were distinct. The decennial census that was officially begun in 1881 had stimulated recognition of group status across the subcontinent, the losses from the Indian famines of 1896-97 and 1899-1900 were fresh in popular imagination, there was expansion of Indian participation into governing councils under Lord Minto, and the previously quiescent Indian National Congress began to garner widespread support. By the turn of the century, India's people served as the primary commodity for the success of the British Empire, and this had a major impact on the way both sides of the colonial interaction viewed each other.⁴⁰⁴

One of the most significant ways that the changing Empire influenced the Indian lunatic asylum was through the changing status of psychiatry as an effective colonial tool. The professionalization of psychiatry consisted primarily of aspirations towards the status of an expert medical subspecialty.⁴⁰⁵ In the previous chapter, I demonstrated how the notion of the expert was key to negotiating the place of lunacy in British Indian

⁴⁰⁴ For example, indentured Indian labour built the 1890s railways that had permitted British possession of East Africa. Metcalf and Metcalf, *Concise History*, 127.

⁴⁰⁵ J. Misbach and H.J. Stam, "Medicalizing Melancholia: exploring profiles of psychiatric professionalisation," *Journal of the History of the Behavioral Sciences* 42 (1): 41-59.

administration. Psychiatry was only able to attain expert status at the end of the nineteenth century, and especially in the twentieth century as opportunities for medical education became available.

As many historians of medicine have shown, the professionalisation of psychiatry in Europe came as the number of universities and psychiatric research clinics rose. Eric Engstrom's study of psychiatric practice in Germany argues that psychiatry's main professional locus shifted from large rural asylums to psychiatric clinics in universities.⁴⁰⁶ While the nineteenth-century lunatic asylum was located at the peripheries of urban centres where alienists used moral treatment upon the socially marginalized, the central location of the university and the existence of other research-oriented sciences nearby, meant that a new cadre of psychiatric scientists were able to transform the goals of the profession. Rather than moral rehabilitation, these new psychiatrists thought of their patients as objects of "medical intervention and scientific inquiry."⁴⁰⁷ Like the lunatic asylum of 1860s India, the psychiatric clinic in German universities was a web of medical students, clinical staff, doctors, patients and the surrounding community, which encouraged professional development and allowed ideas from the clinic's internal space to permeate the outside world.

As the nineteenth century progressed, European psychiatry witnessed a 'neurological turn', by which a new generation of doctors shifted their psychiatric gaze from the whole patient to the specific activities of the patient's brain. This was partly a result of the relocation of the centre of psychiatric inquiry from asylums to research

⁴⁰⁶ Eric J. Engstrom, *Clinical Psychiatry*, 166-170.

⁴⁰⁷ *Ibid.*, 5.

centres, and partly a result of the growing overlap between psychiatry and other medical techniques, such as microscopy, fluid analysis and scientific quantification. This materialist, rather than behaviorist, attitude medicalized psychiatry as a laboratory science, which was interested in the neuropathological basis of mental illness, rather than the social and cultural consequences of deviant behaviour.

By the 1890s, however, alienists in the asylums began to counter the claims of their neurologically minded colleagues in universities. They were concerned at the loss of their professional authority to this new genre of neurological scientist, and were able to argue effectively that the neuropathological approach had done little more to cure insanity than psychology.⁴⁰⁸ Within this battle, Emil Kraepelin gave a resounding defense of psychiatric science as a modern clinical practice. Kraepelin argued that objective observation of his patients was more important than what they said they felt. Through careful and systematic study of patients' symptoms, Kraepelin traced patterns of disease development and created a nosological system of psychiatry, which followed a Foucauldian classificatory rationale. It was his differential diagnosis that made psychiatry amenable to the medical sciences.

Sigmund Freud was also key to professionalisation in European psychiatry. Freud had started out as a neurologist, interested in the anatomy of the brain as key to diagnosing and treating insanity, but he soon lost interest in the clinical approach. By the end of the nineteenth century, Freud had begun to develop a system of psychoanalysis that would provide psychiatry with another point of expertise, and would create a new

⁴⁰⁸ This is not the same as the conflict that arose in the early twentieth-century, between “mechanists” and “holists”, also in Germany. For the later history, see Anne Harrington, *Reenchanted Science: Holism in German Culture from Wilhelm II to Hitler* (Princeton: Princeton University Press, 1996).

locus for treatment: the doctor's office.⁴⁰⁹ Freud was particularly concerned with repressed memories; he promoted a moral and medical message in psychoanalysis, to encourage patients to be 'honest' with themselves, to uncover the traumatic root of their symptoms. In many ways, this morality was a natural extension of the moral treatment already exhibited in many European asylums. However, such a therapy was only a viable option for private patients outside the asylum, as public or pauper patients could not afford lengthy consultations with an expert physician. Freud's work provided new opportunities for those interested in psychiatric treatment beyond the asylum, but Kraepelinian diagnoses were probably more useful in propelling the discipline towards professionalisation than psychoanalysis.⁴¹⁰

While the professionalisation of psychiatry occurred at different rates in Europe,⁴¹¹ by the first decade of the twentieth century psychiatry and psychiatrists had garnered enough authority to be used as effective conduits for European colonialism. The British, French and Portuguese Empires all used colonial psychiatry as their rationale and methodology for colonial conquest. As I mentioned in the introduction, the ubiquity of psychiatric institutions in twentieth-century colonies has engendered the stereotype of the colonial asylum as an archetypal form of colonial power. Jock McCulloch, for example,

⁴⁰⁹ This is not a history of great men working alone. Josef Breuer was Freud's mentor in the 1880s and 90s, and together they published a series of case studies based on the neurophysiological and psychological causes of hysteria. Sigmund Freud and Josef Breuer, *Studies on Hysteria* (London: Hogarth Press, 1895).

⁴¹⁰ With the advent of the First World War and the unfamiliarity of 'shell shock', Freud's psychoanalytic method came to fruition. Shell shock did not exhibit the same patterns of symptoms identified by Kraepelin's diagnostic categories, and there were very clear cases of trauma that could be identified in one-on-one consultation with an analyst.

⁴¹¹ The professionalisation of psychiatry in Tsarist Russia took a rather different turn from the rest of Europe. By the 1890s, Russian universities had established programs in psychiatry, but the early twentieth century saw asylums being incorporated into the tsarist network of 'police' institutions, and psychiatrists were forced to define their roles on political, rather than intellectual or social, foundations. Julie Brown, "The Professionalization of Russian Psychiatry: 1857-1911," PhD diss., University of Pennsylvania, 1981.

argues that ethnopsychiatry, as he labels a distinct form of colonial psychiatry in Africa, was essential to constructing the native African as a colonial subject. Without this construction of the Other, using Freudian ideas of “the primitive”, it would have been challenging to justify many of the colonial interventions into the social and cultural lives of East Africans.⁴¹² Richard Keller has taken McCulloch’s argument even further, by demonstrating how French psychiatrists used colonial scientific discourse to implement a militantly racist colonial order that labeled North African Muslims as inherently violent, amoral and a threat to public safety.⁴¹³ These ideas allowed colonizers to maintain a need for European interventions, including institutionalizing and confining those natives who seemed predisposed to violence and social disruption.

Certainly, by the end of the nineteenth century, territorial conquest of Africa was the primary focus for all European empires. The impetus had begun in 1885 with the Berlin Conference; for the British, this also marked the end of their monopoly over colonial expansion, and they introduced a number of strategies to compete in the ‘Scramble for Africa’.⁴¹⁴ For example, Indian indentured labourers were imported to East Africa to aid with Empire-building.⁴¹⁵ Vincent Khapoya is one of many Africanists who

⁴¹² Jock McCulloch, *Colonial Psychiatry and ‘The African Mind’* (Cambridge: Cambridge University Press, 1995).

⁴¹³ R.C. Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago and London: The University of Chicago Press, 2007).

⁴¹⁴ Otto von Bismarck, the first Chancellor of Germany, organized the Berlin Conference to regulate European colonization and trade in Africa. Rather than imbuing the Scramble for Africa with order, however, the Conference simply legitimized large-scale territorial acquisition by European countries, while simultaneously eliminating many forms of African governance. = Chamberlain, *The Scramble for Africa*, 2010.

⁴¹⁵ M. Tayal, “Indian Indentured Labour in Natal, 1890-1911”, *Indian Economic & Social History Review*, 1977. Indentured labourers were also used in other parts of the Empire, such as the British Caribbean: M. Kale, *Fragments of Empire: Capital, Anti-Slavery and Indentured Labor Migration to the British Caribbean* (Philadelphia: University of Pennsylvania, 1998).

have argued that rapid territorial acquisition in Africa had more to do with the great self-esteem European states felt at possessing a colonial territory so much bigger than their home country.⁴¹⁶

This was the milieu into which the Lunacy Act of 1912 was established. Larger political concerns changed the way the British viewed India within their colonial enterprise. As Sanjay Seth has effectively argued, Western knowledge had traveled eastward, changing what it encountered, and transforming itself in the process.⁴¹⁷ Beginning with educational reform in the nineteenth century, the colonial government had funded schools and universities to disseminate a British notion of modern knowledge, in the hope that it would replace indigenous ways of knowing.⁴¹⁸ The arduous process of education reform took almost a century, during which time both colonizer and colonized began to value imperial ideologies and practices over local knowledge.⁴¹⁹ On the one hand, Western psychiatry and medical education was a means for local Indian men and women to ascend the imperial ladder in British India. On the other hand, the effectiveness of European psychiatry in aiding the colonial effort in Africa meant that colonial psychiatry paradigms were imposed, top-down, to replace the ecology of the lunatic asylum in India with a streamlined and scientific institution of the state. This prioritization of Western knowledge forms was troubling for some Indian subjects, who were “plunged into a moral crisis, leaving them torn between modern,

⁴¹⁶ Vincent B. Khapoya, *The African Experience* (NJ: Prentice Hall, 1998).

⁴¹⁷ Seth, *Subject Lessons*, 4.

⁴¹⁸ John V. Pickstone, *Ways of Knowing: a new history of science, technology and medicine* (Chicago: University of Chicago Press, 2001).

⁴¹⁹ This was so effective that even today, a great majority of knowledge about and in India is based on Western epistemologies.

Western knowledge and traditional Indian beliefs”; arguably this also contributed to the growing nationalistic movements of the early twentieth century.⁴²⁰

This chapter has argued how Western epistemologies came to be integral to Indian professional growth and the transformation of the lunatic asylum in the early twentieth century. Contrary to Sanjay Seth’s exposition of Western knowledge in India, Western psychiatry and the mind sciences were not failing to produce the kinds of modern subjects presupposed by Western governance. The establishment of Ranchi at the end of this period was evidence of a huge transformation in the management of native lunacy in India. Ranchi was a template for scientific psychiatry in the subcontinent: patients were organized within a strictly codified system, doctors came from highly educated backgrounds, and visitors were admitted under the careful control of the asylum superintendent. Architecturally, Ranchi embodied the direction in which all Indian asylums would go: thick walls, a heavily gated exterior, wards instead of houses, and a carefully planned arrangement of trees in homage to nineteenth-century moral treatment. Psychiatry had become a truly colonial endeavour, built upon the intellectual premises of the European medicine, but also borrowing from Indian aspirations within the colonial regime. By using Western-trained Indian subjects in the Indian lunatic asylum, the British were able to impose a strategy of colonial psychiatry in their older colonies as well as their new territorial conquests in Africa. The asylum was still a product of its environment, but the ecology itself had changed: British India was not the same colony as it had been in the nineteenth century, and the legislation governing asylum medicine reflected this.

⁴²⁰ Seth, *Subject Lessons*, 21.

Conclusion

On 8th June 1912, Mrs. Ishanulla, a “non-criminal lunatic, confined in the Colaba lunatic asylum of Bombay” was moved to the lunatic asylum in Agra. She was moved at the behest of her husband, Reverend Ishanullah, who was Archdeacon of Delhi and considered a “venerable gentleman”. The Reverend was concerned that his children and their relatives, who lived in Delhi and Lucknow respectively, would not be able to visit Mrs. Ishanulla “owing to the distance of the place of her confinement from his home” and the “limited opportunity” of visiting the asylum during visitation hours without interfering with his busy schedule. A handwritten note in her file asserts that, as she was admitted as a patient after 16th March 1912, which was “the date on which the new Act came into force” and her husband, as the “proper person to make such a petition” had completed the requisite forms and defrayed all expenses, Section 35 (1) of the new Act permitted her transferring to Delhi Lunatic Asylum in Agra. Mr. Clay, Under Secretary to the United Provinces Government, sanctioned the transfer and forwarded a copy of the orders to the Government of Bombay for record-keeping.⁴²¹

The fastidious record-keeping of Mrs. Ishanulla’s transfer was not unusual. By 1912, the way that asylum superintendents, administrative bureaucrats and even local families managed the treatment of the insane had become highly codified. It was normal for each patient’s admission, diagnosis, transfer and recovery to produce a swarthy paper trail, much to the delight of a historian in the archives. To keep track of Mrs. Ishanulla

⁴²¹ J.M. Clay, Esq., ICS, Under Secretary to Government, United Provinces, to the Secretary to the Government of India, Home Department. Letter no. 30, 8th June 1912. Home Department, Medical B, Nos. 30-31, NAI.

amidst this codified system, we can use her identifier: she was patient no. 13406 in Colaba Asylum. Numbered identifiers, codified petitions and papers, and strict visiting hours reveal the huge transformation that the native lunatic asylum underwent between the middle of the nineteenth century and the second decade of the twentieth. Mrs. Ishanulla's experiences in the British Indian asylum system can be easily located in the papers for the Government of Bombay, the Government for the United Provinces, an archive of the Reverend's personal correspondence, and admissions records in the lunatic asylum at Delhi. A common language of management had also evolved, wherein multiple official parties could communicate effectively using the infrastructure of the British government in India.

Mrs. Ishanulla's transfer is one many examples of psychiatric management from the archives. After 1912, native asylums across India behaved in a coordinated and homogenous system. These were not permeable institutions, filled with multiple actors with their own systems of care; rather, the asylum had been transformed into an archetype of colonial power. Aside from their purpose to confine, treat and manage insanity, these lunatic asylums functioned very similarly to other colonial institutions in India, such as the prison and the hospital, and were complementary to other colonial asylums in the rest of the imperial world.

Taking Stock

This dissertation has examined the rise and collapse of a highly heterogeneous, temporally specific institution in British India. Starting with the enactment of lunacy legislation that was borrowed from Britain, the native lunatic asylum in India was an attempt at asylum reform in a colonial context by a government that was consolidating its

sovereignty over its most valuable colony. There was already a long history of social welfare in the subcontinent, and to this the East India Company, and then the Crown, added more recent theories of the Indian mind. Despite a decade of negligence, the new Government of India surveyed these asylums in 1868 to regain authority over the staff, patients and communities inhabiting these spaces. With successive interventions over a fifty-year period, and the rise of the psychiatric expert as well as professional medicine and medical education in India, the heterogeneous and hybridized practice of care for the insane came to an end.

I started this dissertation with a few questions: why did the British government build lunatic asylums for the native population, when it already possessed colonial hospitals and colonial prisons in India? What was the purpose of a psychiatric institution when European psychiatry had not quite established a coherent set of diagnostic tools with which to admit its patient population? What was the place of lunacy in this hybrid and nascent colonial world?

The native lunatic asylum came out of three distinct trajectories: firstly, the long history of asylum reform in Britain, which prompted new asylum legislation in other parts of the British Empire, including India, Scotland, Ireland and Canada. The success of institutional care in Britain was slowly transported to the rest of the world: regardless of whether asylum patients were cured or not, the opportunity for Britons to contain and remove the insane from civil society was clearly a useful idea in the colonies. The asylum in India was thus not originally a *colonial* institution, but an institution translated into a colony. The EIC did little to change the rhetoric of the 1845 and 1853 British acts: they

only sought to extend the British legislation into India “for the future advantage of Hindustan.”⁴²²

Secondly, the native lunatic asylum extended the existing tradition for asylums and social welfare in India. In an argument for historical continuity, the Crown embraced the existing lineage of European asylums in the subcontinent. Once again, these institutions had had mixed success in “curing” their patients, but cure was not the main goal: they successfully removed the embarrassment of insane European officers from everyday Anglo-Indian life. The Company was primarily concerned with European soldiers or civilians who had gone insane, or “doo-lally.”⁴²³ In theory, the native lunatic asylum had the same goals of removal, isolation and confinement. However, it would prove difficult to “remove” Indian insanes from Indian life without a codified system to help the British staff distinguish between sane and insane Indians. Alternatively, the existence of European asylums in cantonments and urban areas meant that such institutions were familiar to locals, not least because some of them worked in these institutions as attendants.⁴²⁴

Finally, the new Crown government had its own imperial goals in which native asylums made sense. Indian lunacy legislation could be posited as a charitable endeavour

⁴²² T. Hastings, “Lunatic Asylums in Bengal”, *Calcutta Review* 26 (52), 1856: 592.

⁴²³ “Doo-lally” can mean ‘dangerous’ or ‘crazy’. Michael A. Launer traces the origin of the term “doo-lally” to the Deolali dust bowl, a hundred miles northeast of Bombay, where some mentally ill soldiers were effectively abandoned by British authorities, and where heat, heavy drinking and their sexual promiscuity were believed to be both cause and symptoms of their madness: “Doolali-Tap,” *History of Psychiatry* 5 (1994): 533-537.

⁴²⁴ Native staff spent much of their time locking and unlocking European patients into physical shackles in these asylums, reversing the roles of the colonial jail. This irony was not lost on the Inspector General of Prisons: Dr. Archer, Deputy Inspector General of Prisons, Military Department, Lucknow Circle, Annual Inspection Report for the Year 1872 (Lucknow, 7 March 1873). Waltraud Ernst has written a little of these native orderlies in her examination of the EIC asylums: *Mad Tales*, 10.

by a benevolent government seeking to distance itself from its Company predecessor, all the while reasserting its sovereignty over its Indian subjects in an increasingly codified and bureaucratic imperial world. The mentality that discounted Indian abilities and aspirations for self-rule – an attitude that the historian Francis Hutchins has called the “illusion of permanence” – fed into the Crown’s determination to construct yet another colonial institution, on top of the prisons and hospitals it already had in its repertoire, to manage native insanity.⁴²⁵ The native asylum thus presented a continuation and extension of three trajectories for governing Indian insanes in the latter half of the nineteenth century.

By exploring the everyday life inside these institutions, I have demonstrated the disconnect between the theory and practice of native asylum care in the subcontinent. The first generation of these asylums did not fulfill the role of a typically colonial institution: lacking a coherent doctrine for treatment, the asylums were run mainly by Indian staff rather than British officers, and the daily presence of visitors from the local communities meant that Indian insanes were not at all isolated from social, cultural and political lives of their “sane” brethren beyond the asylum walls. No asylum operated in the same way; this was not a systematic, top-down form of institutional care. Each asylum was embedded in a locally specific ecology, with its own set of actors, belief systems and practices. Tea sellers were active elements of this ecology in some asylums, while families, or cooks, or superintendents had the authority to determine the purpose of their particular asylum in other instances. Depending on the nature and number of these ecological actors, the native lunatic asylum operated in a mode that was far dissimilar

⁴²⁵ Francis Hutchins, *The Illusion of Permanence* (Princeton: Princeton University Press, 1967).

from the asylums in Europe, and often quite different from medical hospitals and prisons in the subcontinent, which had a more clearly defined purpose and ideological doctrine. Local men and women, British and Indian, were permitted to enter the asylum and influence its milieu without participating directly in colonial governance.

Examining asylum superintendents' writings was one of the clearest methods to tracking the asylums' transformation. Their asylum reports, their responses to the 1868 asylums survey, the authority of their words in the courtroom and their subsequent specialized or popular publications all reveal the way the asylum changed in this period. The survey shows how variable their practices were, with some superintendents encouraging interaction between local and Westernized systems of asylum care, while others constructed their own treatment systems from the ground up. I have used the term 'hybrid' to describe all of these systems, because so few kinds of asylum care in these institutions were entirely original or discernible as codified and consistent knowledge.

From superintendents' annual reports we also learn how many actors entered the asylum. These asylums were permeable to a greater variety of actors than most histories of psychiatry allow. In part this was because of the economic need to recruit staff members from the local communities, but this in turn fostered a medley of care practices within and rendered the asylum a familiar, not alien or stigmatizing, space in which to visit their friends and relatives, engage in trade, exchange information and know their colonial superiors. The permeable nature of the asylum existed precisely because of the lack of a specifically colonial purpose: the superintendents and their staff were not practitioners of Western psychiatry, nor were they confident in their ability to separate and shun their patients from the local ecology. Coupled with the fact that architecturally

there was no visible difference between the native asylum and other buildings, there was a very low bar to entry.

Over time, the asylum became less permeable, and its practices less hybrid. The Crown was increasingly successful in its efforts to codify the penal system, the medical system and the education system, and this fed into a greater codification and management of the asylum system too. By the twentieth century, the native asylum was staffed by a more coherent community of people, who self-identified as a professional group, and who enforced the paradigmatic boundaries of Western psychiatric medicine at the boundaries of the asylum buildings. The early twentieth-century generation of native asylums were actively planned, using architects familiar with European asylums, and built specifically to practice colonial psychiatry in India. As the physical locus was reinforced and the psychiatric staff became more confident in their roles, so these institutions became less permeable to non-psychiatric ideas even as tea sellers and family members continued to visit.

Superintendents were increasingly visible in the colonial courtroom and Indian journals in the latter half of the nineteenth century. This was a direct correlation with the growing authority of psychiatric or asylum medicine in India, and the rise of the psychiatric expert at large. Whereas local communities had been able to determine the internal practices of the asylum in the 1860s and 1870s, by the end of the nineteenth century the psychiatric expert (the asylum superintendent and doctors) was increasingly dictating the way the community interacted with it. By the twentieth century, native lunatic asylums had become bastions of colonial hegemony; Western-educated Indian men and women were able to discipline the internal and external asylum communities by

dictating who could enter and leave the institution, and by setting limits on the kinds of therapeutic knowledge permitted in their midst. Chai wallahs and cooks continued to visit and work in the asylum, but they no longer had the authority to speak to its practices.

Interventions – Imperial and Colonial History

My intervention in this project has had two prongs: highlighting the potential of the asylum as an analytic lens in the history of colonial India, and extending existing scholarly debate about the “high noon of colonialism” into the ecology of the asylum community.⁴²⁶ Far from being institutions of total confinement, a tool of empire or a practice of systematized dehumanization, the native lunatic asylum of mid-century India was an unusually friendly space.⁴²⁷ The idea of an institution as an interactive site is not unusual in South Asian historiography; however, the potential of the asylum as an analytic lens during this extraordinarily rich and tumultuous part of colonial history remains relatively unexplored. The asylum was embedded in the social and political life of the local communities surrounding it and worked as a fluid concept within the colonial administration for the first few decades of Crown rule. In many ways, the colonial asylum was removed from the tenets of colonial conquest and power, which is a stark contrast from the agreed narrative about the rigorous and authoritarian goals of the new Government of India.

⁴²⁶ For a clear and concise overview of the changing faces of South Asia’s colonial and post-colonial history, see Sugata Bose and Ayesha Jalal, *Modern South Asia: History, Culture, Political Economy* (New York: Routledge 2011).

⁴²⁷ For the notion of an absolute institution, see Goffman, *Asylums*, 3-8. David Arnold has described colonial medicine as a “tool of empire”, enacted primarily through medical institutions such as the colonial hospital, as well as dispensaries, asylums and clinics: *Colonizing the Body*, 5. Frantz Fanon’s work details the power of the colonial asylum to systematically dehumanize and discipline the indigenous population in East Africa, *The Wretched of the Earth* (New York: Grove Press, 1965).

Historians of the British Empire continue to wrestle with their explanations for how such a small number of British administrators were able to colonize and rule so many Indian subjects throughout the nineteenth century. Early answers pointed the limited ambitions of a ‘laissez-faire’ colonial state or the ‘passive collaboration’ of Indians in the construction and maintenance of colonial order.⁴²⁸ However, the recent historiography of modern South Asia has placed the technological and political changes of the subcontinent in conversation with the rest of the empire, showing how the practice of state secularism, development of electoral politics and new religious organizations, and the creating of an educated citizenry occurred in India and Britain simultaneously.⁴²⁹ All of which goes to say, many developments in India were not particularly Indian or colonial, but Britain’s colonial relationship to India was important for their occurring. Indian subjects were thus often no more responsive or reactive than any other subjects in the colonial period.

My work has made a similar argument with regards to the lunatic asylum. Rather than asking how native lunatic asylums were established from the British or colonizers’ perspectives, I have examined the complicity of Indian subjects in creating, managing and inhabiting an institution that had hitherto not existed in the subcontinent. Rather than taking too literally Edward Said’s claims that the empire rested on the creation and perpetuation of false and damaging understandings of the cultures of colonized peoples, I have demonstrated how local communities appropriated a seemingly alien network of

⁴²⁸ Niall Ferguson, *Empire: How Britain Made the Modern World* (New York: Penguin, 2004). Metcalf, *Ideologies of the Raj*, 11. Ronald Robinson’s and John Andrew Gallagher’s extraordinarily influential work, *Africa and the Victorians: The Official Mind of Imperialism* (London: Macmillan, 1961). This was preceded by a widely-read article entitled “The Imperialism of Free Trade.” The latter constitutes a groundbreaking essay among theorists of imperial expansion.

⁴²⁹ Metcalf and Metcalf, *Concise History*, 92-122.

institutions to create a hybridized practice of asylum care that aligned with their own belief systems.⁴³⁰ Certainly there was a rhetoric of disempowerment and control – patients remained the objects of this practice of asylum care, after all – but the permeable nature of the native asylum was a product of the interconnectedness of social and political developments in India, rather than a wholesale transplant from Europe. Psychiatric thought in India, if that is what we can term it, was derivative in many aspects, but it was derived from multiple sources, not just the “scientific rationalism” of post-enlightenment Europe. The lunatic asylum allows us to view the genesis of a locally ensconced system of care, within the larger context of changing sovereignty, regional affiliation and even nascent nationalist or communalist thought.

My project has built thoughtfully upon Chris Bayly’s own work on the networks of indigenous information that were essential to successful governance of India. In the Bayly School of imperial history, colonialism was a cultural undertaking as well as a political or economic endeavour, and this is especially true of the native lunatic asylum.⁴³¹ Just as Bayly wrote in *Empire and Information*, the communities who occupied the local bazaars, the specialists who articulated indigenous systems of knowledge and even the “midwives and marriage-makers” who kept gossip flowing, were essential to maintaining a culture of political and social debate.⁴³² It was only once the Government of India had a distinct system of knowledge – psychiatry – to impose in the

⁴³⁰ Edward W. Said, *Orientalism* (New York: Vintage Books, 2003).

⁴³¹ Christopher A. Bayly, "Knowing the Country: Empire and Information in India," *Modern Asian Studies* 27 (1993): 3-43; and Bayly, *Empire and Information*, 13. In this framework, Indian nationalism triumphed when it managed to wrest control of those intelligence sources from the raj.

⁴³² Bayly, *Empire and Information*, 13.

twentieth century that the informal networks and the greater ecology of the asylum were no longer needed.

Interventions – Medical History and the History of Science

The history of medical institutions has moved away from a focus on doctor-patient interactions, and predominantly clinical interactions, in the last few decades. This was a methodology that had occluded from view those groups of actors who visited hospitals, infirmaries and asylums but were not part of any official or professional discourse. However, some of the most recent work still focuses on how these peripheral actors and social groups reinforced official and institutional health care practices, and does not highlight the way they complicated our traditional narratives.⁴³³ In these newer institutional histories, the asylum remains a powerful tool that exerted Western psychiatric paradigms upon the actors who constituted it. With families constituting the most ubiquitous group of asylum visitors, a number of scholars have exemplified the way they governed the confinement of the insane.⁴³⁴ The number and variety of actors constituting the asylum has expanded, but they still only operate within the system rather constructing their own systems. As a result it is easy to maintain a fairly homogenous spectrum of asylum practice, for example, that does not deviate from specifically psychiatric ideas of madness.

My work suggests that the boundaries of psychiatric medicine were far more fluid and heterogeneous than previously established. Nineteenth century native lunatic asylums

⁴³³ For example, see the recent anthology on medical institutions by Graham Mooney and Jonathan Reinarz (eds.), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (Amsterdam: Rodopi, 2009).

⁴³⁴ David Wright has been especially vocal about this: "Getting Out of the Asylum," 137-155.

in India were simply not coherent enough to behave in as disciplined a system of care as some newer institutional histories assume. In fact, my work shows that there was often no definable system present: asylum superintendents did not share a psychiatric, scientific or social vision; local communities formed heterogeneous viewpoints; attendants within the asylum disagreed over what constituted the best system of care; and the state was at best absent, at worst negligent, in its ability to support this framework.

This lack of systematic coherence, or of clear institutional identity, is difficult for many histories of colonial psychiatry to accommodate. My work is reliant upon the ideas inherent to a particular intersection of time and space: British-built asylums in India, after the asylum reforms of post-Enlightenment Europe and before the consolidation of a professional psychiatry. For many medical historians and colonial historians alike, the asylum has never been an important part of the historical narrative: it was assumed that the asylum was always a bastion of colonial power, always an archetype and never a novelty.

At the end of the nineteenth century, there was a change in the discipline of psychiatry and the mode of governance embraced by the colonial administration. Psychiatric knowledge became valuable, necessary, codified and powerful, the Raj became unapologetically authoritarian. Combined with the rise of the psychiatric expert, increased forms of communication (such as the telegraph and the railway), and the building of greatly disciplined asylums in other colonies (especially in the Indian Ocean World, and Africa), the native asylum of India was transformed into a more visibly colonial space.

One argument for this trajectory has been the heterogeneity and multitude of belief systems that initially established the asylum. Histories of science and SSK have already done much of the work to constructing frameworks for studying heterogeneous ways of thinking simultaneously. John W. Pickstone is one scholar who has sought a reliable methodology for comparing scientific thought from supposedly incommensurable time periods: working on a micro- and macrohistorical level is something I have endeavoured to do in this project, to avoid the historical “flattening” that occurs in grand narratives without adding another case study to a discipline that already has so many.⁴³⁵ The ecology of the asylum is an ideal analytical lens with which to view a number of historical moments in an empire that was both massive and malleable. Developments that occurred inside and beyond India were reflected in tangible ways in the native lunatic asylum. From its undistinguished origins as an extension of social reform in Europe, EIC legislation in the early nineteenth century, and the colonial interaction on the ground, the native asylum in India became a permeable, almost experimental, space in which multiple narratives occur. By the first decades of the twentieth century, however, these same spaces rapidly changed into singularly colonial institutions, organs of a professional psychiatry in which only the voice of the state could be heard.

Final Thoughts

This project has thrown light on the way the colonial asylum can be used fruitfully in South Asian history, the history of psychiatry, and institutional history. Tracking native lunatic asylums and their accompanying legislation has been an effective

⁴³⁵ John V. Pickstone, “Working Knowledges: Before and After circa 1800: Practices and Disciplines in the History of Science, Technology and Medicine,” *Isis* 98.3 (September 2007): 489-516.

way to test – like a chemist’s litmus paper – the nature and quality of British India at very particular moments in time. As Rosenberg has shown with the cholera, using the colonial asylum as a controlled variable is an effective method for tracing the kinds of everyday practices and motifs that usually disappear in the historical record. We can use the asylum, for example, to compare 1858 India with its 1912 incarnation; a form of “intelligent comparative work” that has often been done across space, but not always across time.⁴³⁶

This work suggests that the asylum has an institutional genealogy. Rather than existing, transhistorically, as a universally accepted archetype of colonial power, the asylum can be fluid and permeable to the communities in which it is established. Moreover, the nineteenth-century native asylum in India was more akin to a colonial barracks, before evolving into a therapeutic space like the medical hospital, and then finally an educational space like the university.⁴³⁷ This suggests there is further work to be done, to see if there is a genealogy of institutions inherent to colonial India or the colonial world: do particular ideas of race, sovereignty, citizenship, et cetera, originate in particular institutions, and then trickle down to others? Is there a natural evolution of an institution, from a fluid and experimental space, to a delineated and more regimented establishment?

In many ways, this project was a sociology of space: I explored the institutional forces and social practices that gave rise to a particular ecology that had the asylum at its

⁴³⁶ Maya Jasanoff has managed to perform such comparative work across time and space in *Edge of Empire*, 2005.

⁴³⁷ Mrinalini Sinha writes extensively on the evolving role of the gentleman’s club in British India with one eye on institutional genealogy: “Britishness, Clubbability, and the Colonial Public Sphere: The Genealogy of an Imperial Institution in Colonial India,” *Journal of British Studies* 40 (4), 2001: 489-521.

centre. I then traced its transformation over five decades from a fluid space with permeable walls to an archetypal colonial institution with a clear ideological purpose. My topological concerns were not original – the sociology of space has been an important concept in sociology and postcolonial discourse for some time⁴³⁸ – but it was novel to apply this framework to the history of medicine in mid-nineteenth century India. This framework can go beyond the ecology of the asylum to examine the social and geographical topography of India in a language similar to historians of technology and technological systems.⁴³⁹ This is similar to attempts by historians of the environment to engage proactively with the history of science in India.⁴⁴⁰ My work also speaks to the renewed interest in connecting multiple parts of the Indian Ocean World, broadly defined, to understand the granularity of micro-historical case studies through a larger historical lens.⁴⁴¹ For example, how did the early native asylum influence the movement

⁴³⁸ German sociologist Helmuth Berking argued that local knowledge and the heterogeneity of local spaces continue to inform *globalisierung*, global processes that frame our modern world. Doreen Massey also argues that colonial legacies continue to fuel the way we understand space – our Eurocentric view of the post-colonial world maintains a temporal and spatial distance from the countries that have since gained independence and a non-imperial existence. “Spaces of Politics”, in *Human Geography Today*, edited by Doreen Massey, John Allen, and Philip Sarre (Cambridge: Cambridge University Press, 1999), 279-294.

⁴³⁹ The Society for the History of Technology (SHOT) has done a great deal of work to build conceptual frameworks that connect technology to other aspects of society, contextualizing technological systems and considering social relationships in terms of these systems. See R. A. Buchanan, “Theory and narrative in the history of technology,” *Technology and Culture*, 32 (1991): 365-376, and its response and comment by J. Law, 377-384, and P. Scranton, 385-393. Building on the long history of systems theory, historians of technology have conceptualized multiple ecologies that operate and connect local communities within larger global frameworks. Some scholars have overcome the limits of our vocabulary by creating novel graphic alphabets with which to explain these systems visually. See for example Elisabeth Dostal, *Biomatrix: A Systems Approach to Organisational and Societal Change* (Cape Town: BiomatrixWeb, 2005).

⁴⁴⁰ Vasant K. Saberwal and Mahesh Rangarajan, *Battles over Nature: Science and the Politics of Conservation* (Delhi/Ranikhet: Permanent Black, 2003). See also J.R. McNeill, José Augusto Pádua and Rangarajan (eds.), *Environmental History: As If Nature Existed* (New Delhi: Oxford University Press, 2010).

⁴⁴¹ Michael Pearson made comments to this effect at a recent conference at the Indian Ocean World Centre at McGill University in Montreal. See his “Preface” in *Indian Ocean Studies: Cultural, Social and Political Perspectives*, eds. Shanti Moorthy and Ashraf Jamal (London: Routledge, 2010), xv-xvii.

of indentured labourers across the Indian Ocean, between Western India and East Africa? Can we track the rise of nascent nationalism in the asylum network of the early twentieth century? The asylum is a term that encompasses many kinds of institution, many more than a conservative definition of psychiatry might allow. If we expand our definition of the asylum, to include the fluid spaces that the mid-century native asylum represented, we may reveal much more about the social, cultural and political histories around them.

Why did the British Government build native lunatic asylums in India? This dissertation has answered this question in a number of ways: from the impetus for organization after Company rule, to the local politics of asylum management, to the place of psychiatry in a changing empire and the legislative concerns of a new government in the twentieth century. Another way to ask this question would have been, why did the British Government stop building permeable institutions in the twentieth century?

My purpose in reframing the question here is to suggest that, once we remove the premise of asylums being archetypal colonial institutions, the asylum can behave as an analytical lens that reflects its surrounding communities or ecology, rather than stagnating as a black box of social control. As revealed in the case of individuals in Goffman's *Presentation of Self*, asylums have multiple roles and may serve different purposes for different groups of actors, across space and time. The asylum transformed in the last decades of the nineteenth century, into an institution with which we and the colonial/post-colonial literature are more familiar: an instrument of colonial power. However, the transformation had little to do with the asylum itself; the transformation occurred beyond the institution but, being locally-determined, we can only see these greater transformations inside the asylum. The asylum is a key element to creating

historical frameworks in which the objects of our study are not bounded to their temporal, spatial and social limits.

Appendix

Care and Treatment of Lunatics in India

a Survey by Sir James Clark, 1868

Questions:

- a) Name of Asylum
- b) Situation of Asylum

I – Buildings

- a) Were these originally designed for a Lunatic Asylum?
- b) Do they form part of other buildings, such as hospitals, prisons, etc?
- c) Have they walled airing yards; and if so, what is their size?
- d) Has the Asylum grounds attached to it for the occupation, exercise and amusement of the patients? If so, how many acres do they embrace?
- e) Is the supply of water sufficient, and are other sanitary conditions satisfactory?
- f) What accommodation does the Asylum afford for insane inmates, and how are male and female patients separated?
- g) What is the present population, distinguishing male from female, and Native from European patients?
- h) What is the proportion of single rooms to dormitories, and what is the size of the single rooms?
- i) How many dry rooms are there, and what is their size?
- j) Is there a dining room and recreation hall?
- k) What cubic space is allowed to each patient in the dormitories?
- l) Are the windows furnished with shutters and iron fastenings?

II – Medical Care

- a) How many Medical men are in charge of the Asylum?
- b) Have they other duties, and what?
- c) Do they reside in the Asylum?
- d) If not, how often is the Asylum visited?
- e) Are the Medical men in charge often changed?
- f) Is the Asylum visited by others than those immediately in charge; and if so, by whom, and at what intervals?

III – Ordinary Attendants

- a) Are there male attendants for male patients, and female attendants for female patients?
- b) What is the proportion of attendants to patients?
- c) Are there night attendants?
- d) Are escapes frequent?
- e) Are suicides frequent?
- f) Do the attendants sleep in the dormitories?

IV – Treatment

a) General

- i. Is mechanical restraint employed?

Are hand-cuffs, strait-jackets, muffs, and fixed chairs used?

If so, how many of these mechanical appliances exist in the Asylum?

State under what circumstances mechanical influence is used, and whether during night or day?

- ii. Are there padded rooms in the Asylum?

Or cells for solitary confinement?

Are any of these much used, and for what periods continuously are patients placed in them?

- iii. Of what nature are the provisions for the occupation and amusement of the patients?
- iv. Of the present number of inmates, how many are occupied?
- v. Are baths much used and in what forms, with what objects, and with what effects?
- vi. On what sort of beds do the patients sleep, and what sort are used for those who are wet and dirty in their habits, and what efforts are made to correct those habits?

b) Medical and Dietetic

- vii. Of what character is the dietary?

Is it understood to be liberal?

Are stimulants used?

- viii. Is blood-letting resorted to?

Are narcotics much used?

Are there any special drugs used in the treatment of insanity?

V – Forms of Insanity and Complication

- a) Of the patients at present in the Asylum, how many are considered curable, and how many incurable; how many are insane from birth and how many labour under the acquired forms of insanity, distinguishing Native from Europeans, and male from female?

How many epileptics are there?

How many paralytic?

How many patients with suicidal tendencies?

How many patients with dirty habits?

Is general paralysis of the insane known?

Is maniacal excitement great when it occurs?

Is melancholia frequent, and among Natives is it often of a religious character?

General Queries

- a) Under what authority are patients admitted into, and detained in, the Asylum?
- b) Who pays for the maintenance and care of the patients?
- c) Are the patients generally received while the disease is recent, or is it often chronic and confirmed?
- d) Are persons suspected to be insane first sent to prison and then removed from prison to the Asylum, and how is this removal effected?
- e) State the average number of patients in the Asylum, the whole number of new cases admitted during the year, the whole number of patients discharged cured, the whole number of deaths, the whole number of patients discharged improved, the whole number of patients removed from the Asylum for any other cause for each of two, three, or four years?
- f) What has been observed to be the most frequent causes of insanity?
- g) Is the demand for Asylum accommodation increasing?
- h) Are there many insane persons (idiots, imbeciles, or lunatic) in the country who are not in Asylums; are they under any sort of care, and what is believed to be their condition?
- i) Can the number of admissions into the Asylum for each month for a series of years be given, and the mean temperature for each month at the place where the Asylum is situated?
- j) What is the size and population of the district for whose lunatics the Asylum makes provision?
- k) Is there any peculiarity as to the views held by Natives regarding insanity?
- l) Is any distinction made between the different ranks or castes of the patients in the Asylum?

- m) Are there any private Asylums for the wealthier classes, and if so, what is their state, and are they under any Government inspection?

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Abbreviations

BL – British Library, London
CIP – Central Institute of Psychiatry, Ranchi, India
NAI – National Archives of India, New Delhi, India
NL – National Library, Kolkata, India
WL – Wellcome Library, London

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